

STATE OF NEW JERSEY

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

Application for Fiscal Years 2005 - 2007

Prepared by:

New Jersey Division of Mental Health Services

and

New Jersey Division of Child Behavioral Health Services

with contributions and review by

New Jersey Community Mental Health Board

and

New Jersey Mental Health Planning Advisory Council

September 2004

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

X FY 2005-2007 ___ FY 2005-2006 ___ FY 2005STATE NAME: New JerseyDUNS #: 78168-1101

I. AGENCY TO RECEIVE GRANT

AGENCY: New Jersey Department of Human ServicesORGANIZATIONAL UNIT: Division of Mental Health ServicesSTREET ADDRESS: 50 East State StreetCITY: Trenton STATE: NJ ZIP: 08625TELEPHONE: (609) 777-0702 FAX: (609) 777-0835II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR
ADMINISTRATION OF THE GRANTNAME: Alan G. Kaufman TITLE: DirectorAGENCY New Jersey Department of Human ServicesORGANIZATIONAL UNIT: Division of Mental Health ServicesSTREET ADDRESS: 50 East State StreetCITY: Trenton STATE: NJ ZIP: 08625TELEPHONE: (609) 777-0702 FAX: (609) 777-0835

III. STATE FISCAL YEAR

FROM: September 2005 TO: September 2007
Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Candice R. Covington TITLE: ChiefAGENCY: New Jersey Department of Human ServicesORGANIZATIONAL UNIT: Division of Mental Health ServicesSTREET ADDRESS: 50 East State StreetCITY: Trenton STATE: NJ ZIP: 08625TELEPHONE: (609) 777-0728 FAX: (609) 777-0835 EMAIL: candice.covington@dhs.state.nj.us

STATE OF NEW JERSEY
FY 2005 – 2007 BLOCK GRANT SUBMISSION
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STATE OF NEW JERSEY
OFFICE OF THE GOVERNOR
PO BOX 001
TRENTON
08625

JAMES E. MCGREEVEY
GOVERNOR

May 17, 2004

Lou Ellen Rice
Chief, Grants Management
Division of Grants Management
Substance Abuse and Mental Health Services Administration
Office of Program Services
5600 Fishers Lane, Room 15C-05
Rockville, Maryland 20857

Re: Funding Agreements and Certifications for Federal FY 2005-2007
Community Mental Health Services Block Grant Funds per P.L. 102-321

Dear Ms. Rice:

Per the statutory funding agreements and certifications governing the application for Community Mental Health Block Grant Funds, I am hereby designating Mr. Alan G. Kaufman, Director of the Division of Mental Health Services, within the Department of Human Services, to complete New Jersey's FY 2005-2007 Grant application.

With this designation, Mr. Kaufman is authorized to complete all necessary funding agreements, certifications and assurances governing New Jersey's receipt of these funds.

We look forward to receiving our FFY 2005 allocation so as to continue needed services to our residents.

With all good wishes,

A handwritten signature of James E. McGreevey in dark ink.
James E. McGreevey
Governor

C: James M. Davy, Commissioner, DHS
Alan G. Kaufman, Director, DMHS ✓

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING
AGREEMENTS

FISCAL YEAR 2005

I hereby certify that New Jersey agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State²¹ will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2005, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

21. The term State shall hereafter be understood to include Territories.

- (A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

- (A) the principle State agencies with respect to:
 - (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
 - (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
- (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
- (C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
- (D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

- (A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

- (1) make copies of the reports and audits described in this section available for public inspection within the State; and
- (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

- (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
- (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
- (2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
- (3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

- (b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.


Governor _____
2/15/76
Date _____

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all times (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE


Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL 	TITLE Director Division of Mental Health Services	
APPLICANT ORGANIZATION New Jersey Department of Human Services	DATE SUBMITTED 7/15/04	

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.



PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1689), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age;
- (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7326) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 16 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1988 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL 		TITLE Director Division of Mental Health Services	
APPLICANT ORGANIZATION New Jersey Department of Human Services		DATE SUBMITTED 	

B. OTHER INFORMATION**1. Maintenance of Effort (MOE)**

New Jersey Division of Mental Health Services
 State Expenditures for Community Mental Health Services
 Maintenance of Effort

State Fiscal Year = July 1 through June 30

(Amounts in 000's)

Actual FY 2003	Actual/Est. FY 2004	Est. FY 2005
\$246,385	\$265,663	\$291,123

State expenditures for adult and children's services

2. Set-Aside for Children's Mental Health Services

New Jersey Division of Mental Health Services
 State Expenditures for Community Mental Health Services
 Maintenance of Effort

State Fiscal Year = July 1 through June 30

(Amounts in 000's)

Base FY 1994	Actual/Est. FY 2004	Est. FY 2005
\$20,612	\$47,138	\$51,263

WAIVER AND OTHER SPECIAL REQUESTS**1. Waiver Requests**

Not applicable to New Jersey.

2. Special Requests - Transfer of Funds

Not applicable to New Jersey.

SECTION I. DESCRIPTION OF STATE SERVICE SYSTEM

State Mental Health Planning Council Duties and Appointment Process

The New Jersey Community Mental Health Advisory Board augmented by representatives from mental health advocacy associations, volunteers, family and consumer groups, service organizations, providers and State agencies concerned with the provision of care to children and adults with serious mental illness, constitutes the State's designated Mental Health Planning Council (a full membership listing follows).

Members of the State Community Mental Health Advisory Board are appointed by the State Human Services Board, with the approval of the Governor. The Board's statutory duties (N.J.S.A. 30:9A-2) underscore its role as advocate and advisor to the New Jersey Department of Human Services and its Division of Mental Health Services, on the development of effective mental health services. Members serve specified terms and represent affiliations as defined in statute. It is the responsibility of the Chairperson to initiate a formal request for replacement by the appointing authority within two weeks of a member's resignation.

In order to fulfill the Federal statutory requirements for the Planning Council, the Board is augmented by representatives of State agencies and advocacy organizations, at the invitation of the Director of the Division of Mental Health Services. Together with the State Community Mental Health Advisory Board and the Children's Planning Committee, they comprise the Mental Health Planning Council. Membership meets the requirements of the Federal law governing the block grant process.

In partnership with the staff from the Division of Mental Health Services, the Council oversees the development, annual review and evaluation of the State Mental Health Plan. In order to accomplish this, the Council meets monthly to assess various aspects of the Plan's implementation and to revise the Plan's goals and objectives as necessary.

Contributions of the Planning Council

New Jersey's Planning Council has been in the process of reviewing and refocusing its priorities with the goal of having more impact on improving mental health services for New Jersey's mental health consumers. The Council held a retreat in March 2003 to assist the members to focus more clearly on the issues that needed to be addressed. They cited the following as areas that should be pursued in order to promote a better Mental Health System:

- Better lives for people who are labeled "mentally ill" in an environment that allows people to obtain their fullest potential.
- A system that is aware of and responsive to cultural differences.
- A system that values family and listens to their voices.
- A bottom up approach to planning.
- A movement which includes strong and active consumers.
- Integrated children's and family services.
- Adequate resources to support provider's needs.

As a result of the retreat, the members identified four primary areas of focus for adult services: the Olmstead decision and its impact in New Jersey, availability of housing, co-occurring substance abuse and serious mental illness, and issues associated with consumers involved with the criminal justice system. Subcommittees were convened to develop recommendations for how the Council could address each of these areas. The subcommittees' recommendations were subsequently consolidated into one document focusing on Olmstead-related issues for use by the Governor's Stakeholder Task Force on Olmstead.

The Governor's Task Force developed a set of Core Values and Principles to guide the development of the state's long-term care systems for people with disabilities. The intent was to provide a framework that would enable elements of the system to be measured. They conducted a review of the initiatives developed to strengthen and reform these systems as well as overall progress meeting State obligations under the Olmstead decision. The Task Force established three subcommittees: Nursing Facility, Developmental Disabilities and Mental Health, and developed sixty two recommendations and expected outcomes across sixteen areas that are based on the Core Values and Principles.

The Planning Council subcommittees commented on the Task Force's recommendations in the areas of assessment, Medicaid, Education and Training, Work Force Recruitment and Retention, Housing, Quality Assurance, Public Education and Training, and Wellness and Recovery for Mental Health Consumers. Council members will continue to be involved in the integration of these issues in the statewide Olmstead Plan via their cross membership on the Task Force.

As part of the retreat process, the members also discussed the advisory board's by-laws and the need to assure all Council members have necessary voting authorities and that all are included in Council decision making. A committee to address this issue was convened and the by-laws have since been revised.

In an effort to better utilize the considerable expertise and knowledge of Council members, the Council is currently in the process of surveying its members to determine what meetings, task forces, and workgroups members attend that may have an impact on Olmstead, mental health planning and policy. The goal is for the Council to better understand how these outside activities can best be coordinated with the Council's mission to advocate for improvements to the mental health system as well as to advocate for access to other needed services by mental health consumers and their families. Information from the surveys will be used to inventory the members' knowledge base and to develop strategies for future planning initiatives.

Council Membership

See table following this section.

TABLE 1. List of Planning Council Members

NAME	Type of Membership	Agency or Organization Represented	BUSINESS/FAX PHONE	ADDRESS	CITY	ZIP
Larry Appling	Principal State Agency Representative	Department of Human Services Division of Addiction Services	609-292-7293	120 South Stockton Street, 3 rd Floor	Trenton, NJ	08625-0362
Damyanti Aurora	Advocacy/ Provider Org.	Project Live, Inc.	973-481-1211	408 Bloomfield Avenue 2 nd Floor	Newark, NJ	07107
Sue Benedetto	Family	Family Based Services Assoc. of NJ	732-380-1300	11 White Street	Eatontown, NJ	07724
Jacob Bucher	Consumer	Collaborative Support Programs of NJ	732-780-1175 Ext. 24-Bus 732-780-8977-Fax	11 Spring Street	Freehold, NJ	07728
Richard Cevasco	Principal State Agency Representative	Department of Corrections Division of Operations	609-292-1142	Whittlesey Road P. O. Box 863	Trenton, NJ	08625-0863
Barbara Chayt	Principal State Agency Representative	Juvenile Justice Commission Supervisor of Mental Health Services	609-324-6238 or 609-631-4715	P. O. Box 534	Bordentown, NJ	08505
Courtney W. Clarke	Concerned Citizen	Chair	732-574-0874-Bus 732-499-6736-Fax	384 Regina Avenue	Rahway, NJ	07065
Joseph W. Delaney	Concerned Citizen		732-463-0923	467 Harwick Court	Piscataway, NJ	08854
Thomas N. Denny	Concerned Citizen		973-972-5066	203 Casino Avenue	Cranford, NJ	07016
Jennifer Douglas-Kruk	Advocacy/ Provider Org.	NJ Association of Clinical Case Management	973-470-3522	530 Main Street	Passaic, NJ	07055
David Garagozzo	Family	Family Support Organization of Burlington County	609-265-8838	74 Eayrestown Road	Mount Holly, NJ	08060
Buddy Garfinkle	Consumer	Bridgeway House	908-355-7886	615 North Broad Street	Elizabeth, NJ	07208
Kelly Garlitz	Principal State Agency Representative	NJ Department of Education	609-292-4836	P. O. Box 500	Trenton, NJ	08625

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NAME	Type of Membership	Agency or Organization Represented	BUSINESS/FAX PHONE	ADDRESS	CITY	ZIP
Marilyn Goldstein	Consumer	National Alliance for the Mentally Ill- NJ (NAMI)	908-806-3475	410 Hawthorne Court	Flemington, NJ	08822
Charles Graham	Advocacy/ Provider Org.	Mental Health Emergency Services Association of NJ	856-482-8747-Bus	Steininger Center 19 E. Ormond Avenue	Cherry Hill, NJ	08034
Thomas R. Jones	Principal State Agency Representative	UMDNJ	856-338-1705	1000 Atlantic Avenue	Camden, NJ	08104
Helen Joyce	Principal State Agency Representative	Depart. of Human Services Div. of Family Development	609-631-4540	Quakerbridge Plaza P. O. Box 716	Trenton, NJ	08625
Lynn Kovich	Advocacy/ Provider Org.	Supportive Housing Association Alternatives, Inc	908-685-1444 Ext. 248	600 First Avenue	Raritan, NJ	08869
Sam Laskin	Consumer		856-854-6749	529C-545 Newton Lake Drive North	West Collingswood, NJ	08017
Rosemarie Lobretto	Family	Family Support Organization of Bergen County	201-796-6209	108 29 th Street	Fairlawn, NJ	07410
Madeline Lozowski	Family	Family Support Organization of Union County	908-789-7625	137 Elmer Street	Westfield, NJ	07090
Phillip Lubitz	Family	Vice Chair & NAMI-NJ	732-940-0991	1562 Route 130 North	North Brunswick, NJ	08902
Pam Mastro	Principal State Agency Representative	Somerset County DHS	908-704-6302-Bus 908-704-1629-Fax	P. O. Box 3000	Somerville, NJ	08876-1262
Shannon Milinovich	Advocacy/ Provider Org.	NJ Association of Mental Health Agency, Inc.	609-838-5488 Ext. 222-Bus 609-838-5489-Fax	2329 Route 34	Manasquan, NJ	08736
Robert Paige	Principal State Agency Representative	Department of Labor Division of Vocational Rehabilitation Services	609-777-4930	135 East State Street P. O. Box 398	Trenton, NJ	08625-0398
Joanne Patalano	Principal State Agency Representative	Medicaid Office of Health Svc. Admin. Division of Medical Assistance & Health Services	609-631-4685	Quakerbridge Plaza Suite 11, P. O. Box 712	Trenton, NJ	08625-0712
Thomas Patitucci	Advocacy/ Provider Org.	Catholic Community Services-PACT	973-466-1348	269 Oliver Street	Newark, NJ	07092
Betty Sue Redman	Consumer	Statewide Consumer Advisory Committee	609-523-7100	4410 Pacific Avenue	Wildwood, NJ	08260

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NAME	Type of Membership	Agency or Organization Represented	BUSINESS/FAX PHONE	ADDRESS	CITY	ZIP
Kim Ricketts	Principal State Agency Representative	Dept of Community Affairs	609-292-6420	101 South Broad Street P. O. Box 804	Trenton, NJ	08625-0804
Marilee Ryan	Family	FSO of Mercer County	609-581-6891	427 Whitehorse Avenue	Trenton, NJ	08610
Marie Verna	Consumer	Mental Health Association in NJ	609-656-0110-Bus 609-656-8078-Fax	121 N. Broad Street, 2 nd Floor	Trenton, NJ	08608
Wayne Vivian	Consumer	Coalition of Mental Health Consumer Organization	201-656-6389	1 Congress Street, Apt. C-10	Jersey City, NJ	07307-1043
Helen J. Williams	Consumer		732-780-1175	200 Claflin Avenue	Trenton, NJ	08638
Annette Wright	Consumer/Fam Representative	COMHCO	973-778-7361	408 Sussex Street	Peterson, NJ	07503
Kathy Wright	Consumer/Fam Representative	NJ Parents Caucus	973-659-9922	486 Route 10 West	Randolph, NJ	07869
Sondra Yanniello	Family	Atlantic/Cape May Family Support Organization, Inc.	609-485-0575	2312 New Road	North Field, NJ	08225

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	36	
Consumers/Survivors/Ex-patients (C/S/X)	9	
Family Members of Children with SED	1	
Family Members of Adults with SMI	7	
Vacancies (C/S/X & Family Members)	0	
Others (not state employees or providers)	3	
TOTAL C/S/X, Family Members & Others	20	56%
State Employees	10	
Providers	6	
Vacancies	0	
TOTAL State Employees & Providers	16	44%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State employee and provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services.

PROFILE OF THE STATE

The state of New Jersey is located in the mid-Atlantic region of the Northeast metropolitan corridor, adjoining New York, Pennsylvania and Delaware. Although New Jersey is one of the smaller states in geographical area (46th), it is also considered the most densely populated with 1,134 people per square mile.

As of April 2000, New Jersey's population stood at 8.4 million, an increase of 8.9 percent since 1990. Estimates for 2003 show a 2.4 percent population increase to 8.6 million. The state's population shows increasing diversity. According to the 2000 Census, Non-Hispanic African Americans make up 13.6% of the state's population, Hispanics comprise 13.3 percent of the population and Asians make up 5.7% of the population. From 1990 to 2000, the number of Asians increased by 77.3%, while the number of Hispanics increased by 51 percent. The percent of African Americans showed a more modest increase of 10.1 percent. Non-Hispanic Whites at 6.1 million made up 72.6 percent of the population, with their numbers declining by over 25,000 or 0.4 percent from 1990 to 2000. Census 2000 is the first to include categories for individuals of mixed race and found that 213,755 individuals or 2.5% of the population reported multiple races.

One factor contributing to increased diversity is immigration. The 2000 Census showed that 17.5 percent of the state's population was foreign-born and 25.5 percent spoke a language other than English at home. It is evident that multicultural services are becoming increasingly important. For example, continued growth in the Hispanic population will result in their becoming the largest minority in the state. There will be a need to continually ensure that cultural competence is integrated in service planning for all ethnic populations.

Age will also be an important demographic consideration. In 2000, almost 30 percent of the state's population were members of the postwar generation born between 1946 and 1964. The aging of this group will result in a 30 percent growth in the population 65 years and older in the decade from 2010 to 2020. Child bearing among the postwar generation from 1977 to 1994 contributed to a "baby boom echo" that saw a 21.7% increase in children under five from 1980 to 2000. The number of children from 14 to 17 years old increased 7.5 percent from 1990 to 2000, but is expected to increase 20 percent in the first decade of the 21st century. The number of young adults, 18 to 24 years old is projected to increase by 33.6 percent.

Population shifts continued from urbanized northeastern counties to more suburban regions to the south and west. Of the one million new state residents recorded over the past two decades, 700,454 reside in suburban municipalities where growth totaled 23 percent. Rural municipalities grew by 37 percent, or by 248,951 residents, while urban municipalities grew by only 100,148 or 3 percent.

Transportation and economic concerns continue to be significant throughout the state. There is limited public transportation to link people to jobs and services, particularly in the suburbs and rural areas of the state. Travel time to work, averaging 30 minutes, is the fourth highest in the nation and over 70 percent of commuters travel alone by car. While New Jersey has one of the highest median household incomes in the nation, substantial pockets of poverty remain. In 1999, seven percent of households earned less than \$10,000 and 8.5 percent of state residents were living in poverty. Unemployment rose from about 4% in 2000 to 5.3% by the end of December 2003.

OVERVIEW OF THE MENTAL HEALTH SYSTEM

The New Jersey Department of Human Services, Division of Mental Health Services (DMHS) oversees the State's public system of adult mental health services, offering a wide range of programs and support services. While the Division itself directly operates 5 state psychiatric hospitals, services are predominately based in local communities, where private agencies provide a wide variety of programs and services. The DMHS contracts with 120 not-for-profit agencies, which provide over 700 programs of services to over 200,000 adults annually, 140,000 of whom have serious mental illness (SMI). The State primarily bears the burden of funding the public system of mental health services.

The state is comprised of twenty-one counties. Each county has a Mental Health Board that is staffed by a Mental Health Administrator. The Boards advise the DMHS and the State Planning Council of issues and programs that are of importance to their locale and residents. In addition, each county has a designated Screening Center with mobile outreach and 24 hour access. Screening centers are the legally-mandated gatekeepers for involuntary inpatient treatment into the public psychiatric hospital system. The state's twenty-one counties are organized into three service regions: Northern, Central and Southern (see map). The regions oversee four State psychiatric hospitals for adults and a specialized inpatient facility for forensic patients. Two of the adult regional hospitals also provide specialized services for geropsychiatric patients. There are also six county-operated psychiatric units/hospitals, which operate independently, but receive most of their funding from the State.

Access to short-term inpatient care is afforded at psychiatric inpatient units in local community hospitals throughout the state and admission to county or state psychiatric hospitals is guaranteed to all persons who meet the commitment standard and for whom local inpatient treatment is unavailable or inappropriate. The county-based Screening Centers, not the hospitals themselves, generally determine need for inpatient treatment within the public system. The community mental health system of services provides for three levels of care in each county: (1) acute care programs and crisis stabilization; (2) intermediate care and rehabilitation; and (3) extended/ongoing support programs.

To better serve consumers, New Jersey continues to maintain its commitment and dedication to building a consumer centered and recovery oriented system of care. During the past 14 years, DMHS has implemented a number of initiatives, most recently the Redirection II Plan, designed to reduce reliance on State-operated inpatient care by expanding intensive, high end community services and supports. New Jersey believes that it is the consumers' need that drives the plan of care and that it is the state's role to facilitate and coordinate care that will enable consumers to better integrate into and remain in their communities.

A new Division of Child Behavioral Health Services (DCBHS) was created this year within the New Jersey Department of Human Services in response to the growing need to address the special needs of children in a coordinated, centralized and systematic manner. The goal is to establish a single process for entry into the state system by creating and utilizing common screening and assessment tools and creating an overarching administrative body that tracks children who are screened into the system at any level. In addition, legislation has recently been enacted creating the Office of Children's Services which will act as a single umbrella over the three Divisions most concerned with children's welfare: the Division of Youth and

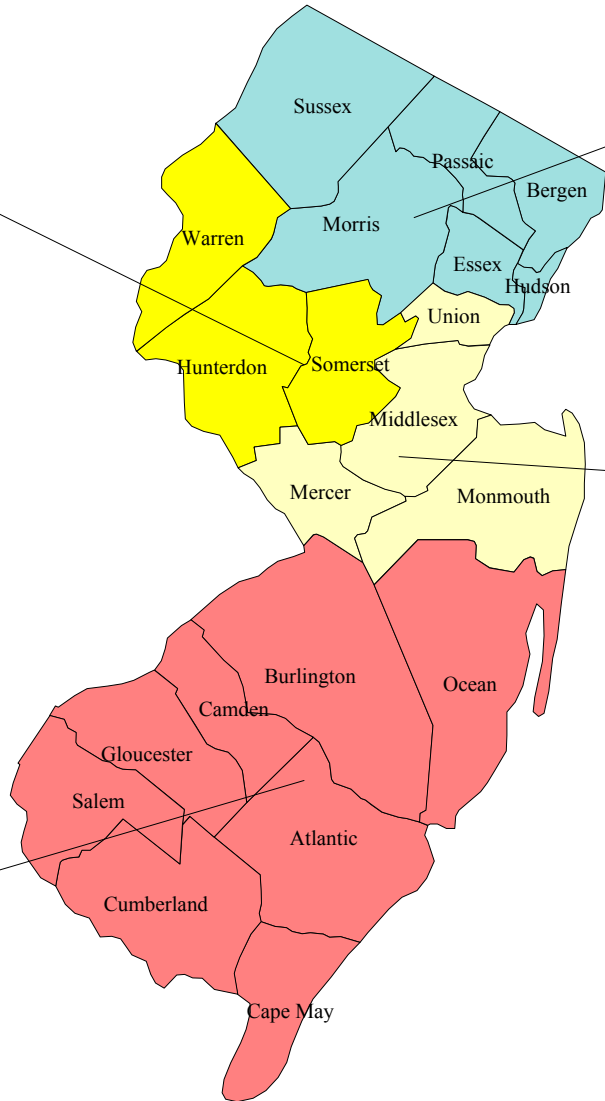
Areas served by G.W.
Hagedorn Psychiatric
Hospital

Areas served by
Greystone Park
Psychiatric Hospital

**N.J. Regional
Configuration**

Areas served by
Trenton Psychiatric
Hospital

Areas served by
Ancora Psychiatric
Hospital



Family Services, the Division of Child Behavioral Health Services, and the Division of Prevention and Community Partnership. An Office of Training was also created as a vital component of the Office of Children's Services.

As a result of the reorganization of children's services, the Office of Children's Services (and its corresponding mental health planning process for children) previously housed in the Division of Mental Health Services, was integrated into the new Division of Child Behavioral Health Services. Planning relating to the mental health needs of children in the Block Application and Mental Health Plan continues to be coordinated between the two Divisions via the adult and children's planners. (See Children's Plan Section).

SUMMARY OF ACHIEVEMENTS/AREAS OF CONTINUING IMPROVEMENT

Over the past fourteen years, New Jersey has taken major steps to consolidate state hospital resources and shift services and funding to meet the diverse needs of mental health consumers within their local communities. The Northern Region Expansion Plan, the 450 Project, and the previously completed three-year Redirection I Plan are specific examples of these efforts. The successful results of these initiatives included dramatic increases in the range and scope of community mental health services as well as fewer state hospital beds and lowered admissions and re-admissions.

Since these efforts proved highly successful over time, they provided a model in the planning of a new initiative: "Redirection II: A Statewide Mental Health Quality of Care Improvement Initiative" which is intended to make additional system-wide improvements in the state's adult mental health system including the following key components:

- substantial expansion of a wide range of community services,
- construction of a new state-of-the art facility to replace the antiquated Greystone Park Psychiatric Hospital, and
- improvements to the quality of care provided in state hospitals and in the community mental health programs.

Work on Redirection II began in the year 2000 with the clinical assessment of more than 1500 patients in the state's four adult regional psychiatric hospitals. Patients were evaluated by hospital staff and also by independent mental health professionals hired by the University of Medicine and Dentistry in New Jersey. The assessments determined that almost 400 patients no longer required intensive hospital inpatient treatment and would be able to return to the community if appropriate services were developed to serve them.

Construction of the new facility also aims to reduce the total number of patients in the four hospitals without reducing staff, and thus dramatically increasing the staff-to-patient ratio and overall quality of care.

With regard to the third aspect of the Plan, it has been widely recognized that resources alone do not necessarily improve the quality of care. Without a concomitant commitment to excellence, a system, while bolstered by new resources, is likely to do "more of the same."

As acknowledged so artfully in the report from The President's New Freedom Commission on Mental Health, if a system of care does not continually strive for excellence by incorporating state-of-the art knowledge in its practices, it cannot effectively meet the needs of people it is designed to serve nor can it meet or embrace the challenges brought about by progress and technology.

In response to these challenges, New Jersey has initiated a number of activities targeted to the understanding and adoption of best practices and evidence based practices that will reflect the unique needs of our system. As mentioned earlier, a major emphasis of the Redirection II Plan has been specifically targeted to furthering our efforts to develop and test new treatments and practices that will improve clinical outcomes for consumers receiving care in state hospitals and community programs. The following represents a brief description of those efforts and the status of these initiatives:

As part of the planning, and to assist with implementation of the Redirection II Plan, a Statewide Advisory Committee (SAC) was formed. The SAC is composed of representatives from key mental health constituency groups including consumers, families, providers and advocates. With input from the SAC, the Division of Mental Health Services established three quality improvement workgroups: Co-occurring Mental Illness and Substance Abuse Disorders, Medication-related Services and Housing-related Services. These groups are co-chaired by a member(s) of the Division senior staff and a representative from the SAC. The groups were charged with identifying and examining promising practices and/or service strategies in their respective areas and with the development of work plans that would identify each group's activities and timelines for their completion. To further their efforts in investigating information in a timely and efficient manner, some of the workgroups formed subcommittees but all continue to meet regularly to share their findings and to develop strategies for implementing new program models and techniques and to update their work plans. A brief description of these activities follows:

Co-occurring Mental Illness and Substance Abuse Disorders Workgroup:

The goal of the Co-Occurring Workgroup is to identify and promulgate promising practices of clinical care for persons with co-occurring disorders. The workgroup formed three subcommittees: best practices; the status of services subcommittee, (charged with surveying providers to develop an integrated inventory of programs and services including model or programs currently provided); and the conference planning subcommittee charged with planning, coordinating and implementing regional forums and/or state-wide conferences to gather and disseminate information. The Workgroup's activities to date have included:

- In October 2003, three regional forums were held across the state that were well attended by a wide array of providers and consumers from mental health and addictions agencies. At each forum, information was shared regarding promising best practices and the information gathered was compiled. It is currently being analyzed by the Workgroup so that recommendations can be issued.
- A survey was distributed to approximately 400 mental health and substance abuse agencies seeking information on best practice techniques currently in use. The results are being analyzed and a compendium of the results will be issued.

- As a result of recommendations from the Workgroup, the Division of Mental Health Services published a request for proposals (RFP) for 3 regional challenge grants designed to develop and enhance services for individuals with serious mental illness and co-occurring substance abuse disorders. On April 16, 2004 awards were made to three programs and a total of \$1.2 million has been allocated on an annualized basis to support these community based pilot programs. As a condition of funding, the programs will be required to develop Tool Kits, mentoring programs, test best practice applications and establish outcome measurements and program evaluation criteria.

It should be noted that, predating the Workgroup's activities, the Division of Mental Health Services and the Division of Addiction Services (DAS) have shared a long history of collaboration and partnership. The DAS, formerly a part of the Department of Health and Senior Services, was moved into the Department of Human Services on June 1, 2004, thereby making it a "sister" to the Division of Mental Health Services. This move will further enhance the communications and joint services planning already underway. The philosophical premise behind the collaboration is "No Wrong Door" which means that services must be accessible wherever and whenever a person enters the system. This will ensure that a person can be treated or referred regardless of the reason, to appropriate services.

The Divisions have recently developed a new demonstration project involving the provision of detoxification and related substance abuse services to individuals with co-occurring disorders. The Divisions are jointly funding detox/rehab beds in five locations across the state for referrals of persons from designated screening centers who have co-occurring disorders but require detox services along with mental health treatment.

Also, the Division of Mental Health Services, through an agreement with the Technical Assistance Center at the New Jersey University of Medicine and Dentistry–University Behavioral Health Center has arranged for the provision of training on the implementation of Integrated Dual Diagnosis Treatment. This treatment approach has been identified as an evidence-based treatment for individuals with co-occurring mental health and substance abuse disorders.

These efforts are consistent with the spirit and legal mandates embodied in the June 1999 Federal Supreme Court's *L.C. v. Olmstead* decision. The court's decision clearly stated that it is incumbent upon each state to ensure that individuals are served in the most integrated settings possible and requires the states to provide community-based services for those persons appropriate for discharge when they desire community placements and treating professionals agree. Although state planning in response to the "Olmstead decision" is wider in scope and ongoing, the Redirection II Plan continues New Jersey's long adopted policy of services provision in the least restrictive setting that is appropriate to the individual's needs.

Although implementation of the Redirection II Plan continues, it has already resulted in the following improvements:

- \$30 million additional dollars has been appropriated for the Redirection II Plan.

The Division has contracted with community agencies for 509 additional new community residential spaces to be utilized for consumers appropriate for discharge, plus 104 supportive housing spaces for persons already in the community.

- A total of 31 PACT teams operate in 21 counties.
- Integrated Case Management Services (CMS) provide a minimum of 18 months follow-up to all consumers discharged from state and county hospitals. This was expanded under Redirection II to include people coming out of short term care facilities who have a history of two or more hospitalizations within a 12 month period.
- 19 Advanced Practice Nurses initiatives will begin.
- In collaboration with the Division of Addiction Services (DAS), three pilot programs were developed to work with people with co-occurring substance abuse and mental illness. (\$1.2 million allocated annually for the programs).
- Programs will be implemented to provide referral detox services for screening centers for persons presenting with primary substance abuse issues.

Mental Health Disaster Planning

Concurrently, mental health disaster planning has also been an evolving process in New Jersey for over the past fourteen years. The Division of Mental Health Services has collaborated with a multitude of public and private emergency response organizations and state departments in an effort to continue to move the state forward in its development of the mental health emergency response system. Emergency mental health response to community incidents or declared disasters has developed into an increasingly coordinated process. At the same time however, much remains to be done. A majority of the counties have mental health emergency response plans and call-up rosters, and have used them to respond to community incidents such as fires, airplane crashes, homicides, traumatic events affecting schools, and most recently, the World Trade Center Disaster and anthrax threats.

In response to the World Trade Center Disaster, a comprehensive program called Project Phoenix was developed using \$6.5m from the Federal Emergency Management Agency (FEMA) and \$3.4 million from the Substance Abuse Mental Health Services Administration (SAMHSA). An array of services including outreach, psycho-education, individual and group counseling and referral services, were provided to people directly affected by the disaster as well as to the general public, particularly in eleven designated counties. A continuum of care was provided ranging from psycho-education services to clinical counseling services to meet individual needs.

The current focus is on preparedness activities to incorporate an all hazards planning approach including the participation of all state and local public and private stakeholders. The ongoing challenge is to continue to address the escalating demands for mental health disaster preparedness and response with limited fiscal resources and a widely dispersed and changing pool of trained professional counselors.

NEW DEVELOPMENTS/ISSUES

Best Practices/ Activities

New Jersey has made significant progress in implementing and enhancing services that are evidence based. Specifically, there are 31 Programs in Assertive Community Treatment (PACT), 21 Supported Employment Programs (SEP) and 23 Intensive Family Support Services programs in each of the state's 21 counties. Additionally, as noted in the information presented below, New Jersey is moving ahead in implementing practice areas of illness management and recovery, co-occurring substance abuse and mental illness, and medication-related services.

Medication-Related Services Workgroup:

No one treatment modality is more significant than that associated with medications in the treatment of serious mental illnesses. This Workgroup, co-chaired by the Division's Medical Director, the Division's Director of Consumer Affairs and the Executive Director of the NJ Association of Mental Health Agencies recognizes the significance as well as the importance that understanding all aspects of medication plays in illness management and recovery programs.

Because of the breadth of information and issues, the Medication-Related Services Workgroup divided itself into the four following subcommittees: Evidence-Based Practices; Interface; Resources; and External Issues. The four subcommittees identified problem areas relevant to medication related services and offered recommended strategies to address issues identified by the respective groups. Issues ranged from the lack of clinical time in the community to the challenges associated with changing formularies by insurers and other entities involved in medication administration. There was, however, one over arching issue – the need for educational and training opportunities for hospital and community staff regarding medication adherence and evidence-based practices relevant to medication related services.

On June 25, 2003, DMHS held a state-wide conference "Fostering Collaboration and Improving Communication in Medication-Related services: An Approach." Nationally recognized experts on medication adherence and illness management and recovery (IM/R) provided presentations and helped to initiate a dialogue with consumers, family members, and staff from state hospital and community programs over what practices hold the greatest promise for improving medication related services.

After several subsequent meetings, the Workgroup finalized its plan and the following new initiatives were agreed upon by the Workgroup:

- An expansion of the Advanced Practice Nurse Initiative which was first started in 1997. The goal of this program is to enhance the utilization of psychiatric advanced practice nurses in order to demonstrate the feasibility and impact of utilizing nurse practitioners to augment the availability and provision of client medication administration, management and monitoring services. These are seen as a major treatment component for those individuals who reside in the community and, when tied to individual assessment and evaluation, as well as psycho-educational programs, linkage and follow-up, are crucial to maintaining an individual on prescribed medications.

- A tobacco dependency project that would address the serious problem of tobacco dependency among mental health consumers. DMHS will contract with UMDNJ Tobacco Dependence Program to develop a treatment manual that will be piloted in mental health settings across the state.
- DMHS has contracted with the Center for Excellence in Psychiatry (CFEP), a part of UMDNJ-UBHC to pilot “Team Solutions,” a program proven to have positive results in improving overall physical and mental status using illness self management and self directed care techniques. The program is being provided in all adult state psychiatric hospitals, will be piloted in selected community mental health settings and will provide enhanced staffing and supports.
- DMHS will also contract with the CFEP to implement Illness Management and Recovery (IM/R) programs in community and state hospital programs. This practice will be implemented with the assistance of nationally renowned experts in IM/R. Within the next 12 to 18 months a series of regional training sessions will be provided throughout the state to promote the model. Pilot sites will be selected to ensure that facilities dedicate the appropriate staff resources needed as well to ensure that implementation follows the model.
- Implement a collaborative “Disease Management” initiative between the Divisions of Mental Health Services and Medical Assistance and Health Services (Medicaid) for the purpose of improving the quality of prescribing practices among practitioners prescribing psychotropic medications. The Medicaid database will be accessed to provide information about the practice of poly-pharmacy and to identify potentially inappropriate or less effective practices. Letters and phone calls will be directed to those practitioners identified with the goal to educate them about clinically sound and more cost effective approaches to prescribing psychotropic medications.
- Mental health consumers will be surveyed directly regarding their needs, perceptions and attitudes about medication related services. The survey will be distributed at upcoming consumer events and the results will be incorporated into future medication related services initiatives.
- The Workgroup will sponsor the production of personalized medication diaries/record keeping pamphlets to be distributed to mental health consumers to assist them in managing their medications and to help them establish a personalized record of their medication histories.
- The Workgroup is researching medication education materials and medication fact sheets for use in hospital and community settings. These will enhance the goals of illness self management and foster collaboration between the consumer and the practitioners across multiple treatment locations.

Housing-Related Services:

The SAC recognized the importance of decent and affordable housing to persons with serious mental illness and thus recommended that housing related services become a specific focus area. An important aspect of this Workgroup's deliberations has centered upon the housing services/programs currently provided by the Division via purchase of service contracts with private non profit organizations. Currently there are over 3700 contracted or licensed residential spaces in our system.

This Workgroup, and its three subcommittees, has been active in the following areas:

- Developing uniform standards/minimum attributes for admission, continuing stay, step down and discharge for the various levels of care being provided through the Division's contracting system.
- Determining the treatment, rehabilitation and support services that are necessary and should be provided throughout the housing continuum and with other programs such as partial care, PACT, etc.
- Identifying strategies to increase and improve partnerships with other agencies that would lead to the development of new housing units
- Coordinating the development of an on-going train-the-trainer program for staff in various community mental health programs that will concentrate on accessing subsidized resources, working with landlords etc. A written set of uniform practices and guidelines is expected to be developed for these training sessions.
- Exploring how to improve access to all types of housing programs and the improved utilization of current spaces
- Developing a centralized inventory of housing resources and a means for accessing and prioritizing needs
- Identifying evidence based and best and emerging practices for "community living skill" interventions that improve consumer self-management
- Promoting the use of practices and developing fidelity measures for each type of intervention to facilitate self assessment
- Creating technical assistance opportunities that champion the understanding and use of best practices

OTHER EVIDENCE BASED/BEST PRACTICE INITIATIVES AND ACTIVITIES

Pharmacological Practice Guidelines for the Treatment of Schizophrenia and Bi-polar Disorders

Clinical Practice Guidelines are an effective approach to improving prescribing practices and in this regard "Pharmacological Practice Guidelines for the Treatment of Schizophrenia" are currently being implemented in all of the adult state psychiatric hospitals. Similar guidelines are also under development for the treatment of bi-polar disorders. These guidelines structure orientation and training for clinicians, provide

objective treatment goals, allow outcome measurement, and guide quality improvement and monitoring of cost-effective prescribing. They also emphasize that decisions regarding medications should be made collaboratively with the patient, and be based on past treatment response and individual preferences, as well as the side effect profiles and costs of alternative treatments.

SECLUSION AND RESTRAINT

In 1999 the Division initiated a statewide plan for the reduction of seclusion and restraint in the state hospital system. Each of New Jersey's five adult state operated psychiatric hospitals submits seclusion/restraint data to NRI/ORYX to measure outcomes and to establish benchmarks with other facilities – statewide and nationally. This data is reviewed at the hospital level and by the Division's Executive staff.

As a result of this initiative, the following activities have occurred:

- DMHS Administrative Bulletin 3:21, "Seclusion and Restraint in the Continuum of Care" was revised in April 2000 to include standardized guidelines consistent with current best practices.
- In June 2000, all state psychiatric hospitals were required to revise their facility specific seclusion/restraint policies and procedures to ensure compliance with the provisions of the revised Administrative Bulletin.
- A state-wide Seclusion/Restraint Reduction Workgroup was convened which included clinical management level staff from each hospital, the DMHS Medical Director, administrative and clinical support staff, a consumer affairs representative and a consumer advocate. This Workgroup reviews practices and performance improvement initiatives at each state hospital and develops statewide initiatives.
- In May 2003, the Division participated in the NASMHPD/NTAC regional training initiative "Creating Violence Free and Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint."
- In October 2003 the Director of the Division of Mental Health Services promulgated a "Position Statement on Seclusion and Restraint" directed to all state operated facilities.
- In October 2003, a seclusion and restraint "kick off" training event was held for the Children's Services System which included our state children's psychiatric hospital and community based children's crisis intervention services. The training utilized the curriculum material provided by NASMHPD/NTAC and was assisted by two of the children's services consultants utilized at the NTAC regional training.
- In December 2003, a seclusion and restraint "kick off" training event was held for the adult hospital services system which included administrative and clinical leadership from the four regional adult state hospitals as well as the forensic state hospital. Again, the curriculum model was based on the NASMHPD/NTAC/NETI training curriculum. Representatives from NTAC and the Pennsylvania state hospital system were invited to participate. Ancora

State Psychiatric Hospital, NJ's project facility presented the Seclusion and Restraint Reduction Work Plan at this session.

- In the summer of 2004, reviews will be completed of each state hospital's Seclusion and Restraint Reduction Work Plans. These reviews will be conducted by the Seclusion and Restraint Reduction Workgroup.
- Current training curriculums utilized for therapeutic interaction and restraint techniques are under review. These will be replaced/revised with curricula that emphasize prevention and de-emphasize "hands on" techniques. It is expected that there will be full implementation, including training by late fall 2004.
- Also, by late fall, Administrative Bulletins will be revised to strengthen consumer participation in the provision of services, on committees, in training and decision making processes and to address trauma screening and assessment.

PSYCHIATRIC ADVANCED PRACTICE NURSE INITIATIVE

The Advanced Practice Nursing (APN) initiative was first started in 1998. At that time \$1.8 million (and later increased) was made available annually from the Redirection I Plan to add 21 APN's to community mental health programs to meet the increasing demand for medication management services. As a result of the success of the program, an additional \$2.2 million was made available from the Redirection II Plan to fund an additional 19 APN's in community mental health programs in 14 counties. The APN's conduct comprehensive health and mental health assessments of acute and chronic conditions, assist in the formulation and implementation of treatment plans, provide medication prescribed under joint protocols, and evaluate the effectiveness of the plan of care throughout the course of treatment.

Hiring another 19 fulltime equivalent nurses to further Best Practices in the areas of medication adherence and psycho-education will greatly enhance the provision of services to persons with serious and persistent mental illness. There is now a total of 45 funded APN positions.

Recent Legislative Initiatives/Changes

- The New Jersey Legislature is considering a bill that would relieve many patients of the financial burden for their care, and abolish or reduce the circumstances under which the State must place a statutory lien on a former patients' property. The bill was reintroduced this term and is still being reviewed by the Department of Human Services and various advocacy groups.
- The Legislature recently passed a bill requiring that the Division of Mental Health Services promulgate joint regulations with the Department of Corrections to establish the rights and responsibilities of persons civilly committed as sexually violent predators. While such individuals are committed to the custody of the Department of Corrections, the DMHS is responsible for provision of treatment services. The Attorney General's office is coordinating the collaboration required by the bill. The regulations are drafted and being circulated in both departments for review and comment.

- Several community incidents and two recent deaths of jail inmates with mental illness have spurred the introduction of several measures that would study and/or change the way offenders with mental illnesses are treated and referred into the public mental health system. These bills are being deliberated in both houses of the Legislature.
- The Legislature passed a bill which was signed in January 2004 requiring mental health and education professionals to report youth suicides to the state mental health authority. A Youth Suicide Prevention Advisory Council was established as a result of the legislation to devise a public education and professional resource strategy to deal with youth suicide. Appointments to this council are expected in the future.
- Legislation was passed this year to create the Office of Children's Services within the Department of Human Services (DHS). The Division of Youth and Family Services, the Division of Child Behavioral Health Services and the Division of Prevention and Community Partnership are now organizationally under DHS as a result of this legislation.

SECTION II: IDENTIFICATION AND ANALYSIS OF THE SERVICE SYSTEM'S STRENGTHS, NEEDS AND PRIORITIES

A discussion of the strengths and weaknesses of the system:

Major Strengths:

- Integrated planning for community and state hospital systems.
- Emphasis on the expansion and enhancement of diversionary services including:
 - Emergency Services and Screening/outreach
 - Short Term Care Facilities (STCF) that provide involuntary inpatient treatment in community based general hospitals
 - Integrated Case Management Services provided for up to 18 months for all persons discharged from a state or county psychiatric hospital, or from a STCF for persons with multiple admissions.
 - Programs in Assertive Community Treatment in each of New Jersey's 21 counties
 - Utilization and expansion of Supportive Housing and DMHS housing subsidies
 - Utilization of Supported Employment in all 21 counties and development of Employment Institutes
- Emphasis on consumer empowerment, wellness, and recovery as the foundation of services, and the expansion and enhancement of consumer operated services.
- Expansion of services to families of persons with serious mental illness including psycho-educational programs and intensive support services in all 21 counties.
- Collaboration with the Division of Addiction Services to coordinate and expand programs to serve persons with co-occurring mental illness and substance abuse.
- Development of clinical consultation and outreach services for consumers with developmental disabilities and mental illness.
- Strong participation by the mental health community in the Governor's Stakeholder Task Force on the *Olmstead v. L.C. Decision*.
- Development and utilization of Advanced Practice Nurses programs on a statewide basis to expand and improve access to health care and medication services.

- Active involvement of the mental health constituency groups and other state agencies in the planning and implementation of major mental health initiatives.
- Movement toward practices, best practices and outcome measurement in community and state hospital programs in the following areas:
 - Illness Management and Recovery
 - Medication Management
 - Seclusion and Restraint
 - Co-occurring Substance Abuse and Mental Illness

Challenges facing the public mental health system:

- Infrastructure needs of community mental health and state hospital programs, and the increasing demand for services.
- Increasing demands for mental health services for persons who are mentally ill and facing criminal charges, currently in jails and prisons, or those released from these facilities without adequate pre-release planning.
- Lack of sufficient and accessible affordable housing for all people with disabilities.
- Meeting the increasing demand for mental health services across all geographic areas and population groups.
- Recruitment and retention of a qualified and motivated workforce.
- Provision of services that are sensitive and relevant to the state's diverse population, delivered by multi-culturally competent staff.
- The realization of a seamless delivery system for persons transitioning between child and adult services.
- Continued development of a comprehensive and coordinated mental health disaster response plan with a limited workforce, expanding range of types of disasters, and widening populations directly effected.

An analysis of the unmet needs and critical gaps within the current system:

- In New Jersey, the lack of sufficient affordable housing continues to be a formidable challenge for all people but particularly for those who are disabled and on fixed incomes. Moreover, this critical shortage stymies efforts to move individuals with serious mental illness from institutional or congregate care settings to more independent housing.
- A lack of sufficient, meaningful employment for persons with serious and persistent mental illness. Employment is essential for achieving and maintaining community integration.
- Insufficient community services to facilitate immediate discharge for hospitalized consumers appropriate for placement, or to divert otherwise unnecessary hospitalization.

- Need to expand and improve the quality of services provided in hospital and community programs and assure use of evidence-based practices where applicable, up-to-date training, and coordination/communication among all sectors.

A statement of the State's priorities and plans to address unmet needs:

- Emphasis on Quality Improvement including the adoption of services and best practices that support the unique needs of persons with serious and persistent mental illness.
- Establish data collection, evaluation criteria and performance measurements for those practices.
- Work collaboratively with the state's Medicaid authority to monitor the use of services by persons with serious mental illness with the goal of maximizing services and resources.
- Continue participation in the statewide cross-disability Olmstead Advisory Committee.
- Assist in the transition of mental health services for children and youth from the direct auspices of the Division of Mental Health Services to the newly established Division of Children's Behavioral Health (both Divisions located within the Department of Human Services).
- Continue Redirection II to develop additional community mental health services for both hospital patients appropriate for discharge and those already in the community.
- Continue collaboration with public and private agencies whose services directly impact upon persons with serious and persistent mental illness.
- Continue to develop integrated data systems that support decision making and planning.

Despite population growth and increasing demand for mental health services, the following statistics are examples of some, although not all, of the significant progress that has been achieved in New Jersey's mental health system during the period of 1995 – 2004:

- State hospital census has decreased by 9.3%
- Admissions to state hospitals has decreased by 11.5%
- Community spending has increased by 74.9% from \$160.681M to \$281.008M.
- Development of STCF beds in local general hospitals has increased from 0 to 274.
- 18 consumer operated programs have been implemented totaling \$6,524,917
- 23 family support programs were implemented totaling \$3,458,586

- Programs for Assertive Community Treatment (31 Teams) have been implemented in every county totaling \$20,238,420.
- The number of contracted/licensed residential beds has increased by 104% from 1,916 to 3,914.
- Integrated Case Management Services were implemented state-wide and provide 18 months of follow-up care to all persons discharged from state or county hospitals, or designated community psychiatric inpatient services for persons with multiple admissions.
- Development of Advanced Practice Nurses program encompassing 45 APN's in 21 counties.
- Supportive housing spaces have been developed in the community, and 591 consumers receive state mental health housing subsidies.
- Number of persons served in community (or episodes of care) has increased from 221,421 to 318,398.
- New construction of (replacement) state hospital beds has been completed for the Forensic Center (200 beds); Hagedorn Psychiatric Hospital (100 beds); and an Intensive Treatment Unit at Trenton Psychiatric Hospital (34 beds). Construction is currently underway to replace Greystone Park Psychiatric Hospital with a new state-of-the-art facility (460 beds).

As important as the quantitative growth witnessed during this time has been, it is equally important to acknowledge that without the philosophical underpinnings that have driven the system's enhancements, services -- while more plentiful -- would not reflect the needs and desires of those most affected by them. Because of that, our progress has been anchored in the following values:

- Consumer and family empowerment.
- Improving and enhancing access to quality mental health care including the newest pharmacological advancements.
- Recovery is possible and necessary for continued community integration.
- Comprehensive acute and diversionary services are necessary to support successful community living.
- Services must be flexible to meet the individual needs of consumers.

Description of how the state mental health agency provides leadership in coordinating mental health services within the broader system:

As the State Mental Health Authority for adult services, the Division of Mental Health Services has varying roles. These include:

- Direct Service Provider (the state psychiatric hospitals)
- Purchaser of services (community programs and county psychiatric units or hospitals)
- Regulator of standards and services (inspections and standards of care)
- Coordinator for immediate mental health disaster response
- Systems planner

In carrying out these functions, the Division must take the lead to ensure that there is continuity of care and coordination of services within the State and between the public and private sectors. In doing so the Division must provide leadership in the following areas:

- Interface between the state and county psychiatric hospitals and community providers
- Establish or participate in key advisory boards and committees whose missions impact upon the delivery of mental health care and treatment
- Promote effective communication internally as well as with the broader mental health and human services communities
- Represent and advocate for the needs of the mental health community at the state and federal levels
- Initiate planning activities, with input from key constituents and interested parties, that address the changing needs of the state's residents

FORMAT

The following section addresses the five Legislative criteria for adults. Please see the Children's Plan section for criteria addressing children's services.

SECTION III: PERFORMANCE GOALS AND PLANS TO IMPROVE THE SERVICE SYSTEM

CRITERION 1

Comprehensive Community-Based Mental Health Service System

A comprehensive community-based system of mental health care for SMI adults and for Youth with Serious Emotional Disturbances, including case management, rehabilitation, employment, housing, educational, medical, dental, and other support services, which enables individuals to function in the community and reduces the rate of hospitalization and residential placement will be developed and implemented.

New Jersey's community based mental health system has made significant progress within the last decade. State expenditures for community services now surpass funding for state hospital programs. This is due in large measure to closer collaboration with the state Medicaid agency and a succession of multi-year projects that have redirected institutional dollars from state hospitals to support a wide variety of community based services for adults with SMI. While the state hospitals have been downsized and their programs consolidated, a portion of the redirected dollars were specifically earmarked for the hospitals to ensure the continuation of programs and staffing needed to meet the needs of those residents requiring a more secure program setting.

The community mental health system continues to evolve as demonstrated by the marked progress that has occurred in the types and numbers of programs available in local communities. More /best practice services such as PACT, supported employment, and supportive housing are available (refer to Basic Table 16 following this narrative) while others, such as Illness Management and Recovery, are under development (refer to Basic Table 17 following narrative). Also, consumer operated/directed services have increased as have those services that provide support and psycho-educational services to the families of persons with serious mental illness.

Of course, an important element in measuring the successful implementation of these new programs centers on how those receiving the services feel about the services they receive. In this regard, in November 2003, the Division conducted a survey of PACT consumers (refer to Basic Table 11) using a modified MHSIP survey instrument. As shown by the data, over 87% of those persons surveyed indicated that they were satisfied with the services they received. Additionally, consumers responding to the survey reported positively on the appropriateness of the services and the outcomes. Annual consumer surveys are planned and the results from one year to the next will be analyzed and compared to ensure that the program continues to meet its objectives.

Throughout this period of expansion, emphasis has been placed on the development of acute care and diversionary services. Emergency/screening services, Short Term Care Facilities (involuntary inpatient care in general hospitals), PACT, and Integrated Case Management Services provide a variety of intensive interventions directed at preventing inappropriate hospitalizations at state facilities whenever possible. Those persons requiring admission to state hospitals are generally from economically challenged areas and whose psychiatric illnesses are often complicated by serious

medical conditions and/or substance abuse. While overall re-admissions at 30 and 180 days continue to decrease, (refer to Basic Table 20A) readmissions for some minority populations have not decreased as much as for others. In partnership with community mental health providers, additional efforts are being reviewed that will further reduce the number of re-admissions, especially for minority patients and those with medical needs and/or co-occurring substance abuse issues.

It should be noted that New Jersey has applied for a continuation of its Data Infrastructure Grant. It is with the resources from this grant that the Division proposes to modify and expand several of its existing information systems in order to be consistent with all of the Uniform Reporting System (URS) data tables, and to improve its capacity to identify consumer needs, to evaluate program effectiveness and to respond to emerging issues.

As noted in Table 1 "DMHS Community Services: Evaluation Data Episodes of Care" almost 320,000 episodes of care were provided during State Fiscal Year 2004. If funding remains constant, it is expected that there will be modest growth in the number of episodes of care in most service elements for the period 2005-2007. It should be noted that during SFY 2005 the last of the new and/or enhanced Redirection II programs will be implemented thus ending a three to four year period of program expansion. While additional new program funding cannot be guaranteed at this time, several areas are being preliminarily reviewed and efforts will continue to further implement quality improvement strategies in state hospital and community programs that are directed at enhancing effectiveness and efficiency.

In addition to the mental health initiatives described throughout this Plan, cross disability planning has occurred through the state-wide Olmstead Advisory Committee which was first convened in 2000. The planning and advocacy that occurs in this forum is also vital to improving the quality of life for mental health consumers for it is at these meetings that issues affecting all disabled persons are discussed and action plans developed. Through the Olmstead Advisory Committee, the "common" interests/needs such as housing, education, rehabilitation, employment, transportation, education and access to general health care have been discussed, prioritized and promoted as reflected in the Olmstead State Plan "Achieving Community Integration For People With Disabilities Phase I."

The Olmstead Advisory Committee meetings provide an important opportunity for various disability groups to put forth a common agenda that will benefit all disabled people regardless of their specific disability. Also, the Olmstead Advisory Committee has reaffirmed the importance of providing opportunities for people with disabilities to move from more restrictive institutional settings such as state hospitals, developmental centers and nursing homes to rehabilitative programs located in the community. The mental health community is well represented on the Olmstead Advisory Committee thereby ensuring that policy and planning initiatives emanating from this group are inclusive of the needs and desires of mental health consumers.

NUMBER OF ADULTS WITH SERIOUS MENTAL ILLNESS RECEIVING SPECIFIC SERVICES DURING THE YEAR

State **NJ**
Reporting Year **FY 2004 Estimated**

	Adults with Serious Mental Illness (SMI)				Children with Serious Emotional Disturbance (SED)	
	n Receiving Supported Housing	n Receiving Supported Employment	n Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI served	n Receiving Therapeutic Foster Care	Total unduplicated N - Children with SED
Age						
0-3						470
4-12						6,600
13-17			3			8,519
18-20			3	5,745		
21-64			1,613	91,945		
65-74			149	6,905		
75+			56	7,885		
Unknown			16	166		
TOTAL	1,600	1,637	1,840	112,646	487	15,589
Gender						
Female			828	57,449		5,995
Male			1,012	55,197		9,567
Unknown						27
Race/Ethnicity						
American Indian/ Alaskan Native			4	1,093		93
Asian			20	1,140		151
Black/African American			519	27,148		4,811
Hawaiian/Pacific Islander						
White			1,128	64,321		6,384
Hispanic*			131	16,334		3,658
More than one race						
Other			39	1,802		361
Unknown				809		131
Hispanic/Latino Origin						
Hispanic/Latino Origin				16,334		3,658
Non Hispanic/Latino				95,502		11,800
Unknown				810		131

Do You Monitor Fidelity for this Service? Yes ☐ No ☐ Yes ☒ No ☐ Yes ☐ No ☐

IF YES,

What Fidelity Measure Do You Use?			Subset of Dartmouth ACT Scale			
Who Measures Fidelity?			PACT Coordinator			
How often is Fidelity Measured?			Monthly/Quarterly			

* Hispanic is part of the total served. Yes ☒ No ☐

* Only Report Hispanic as part of the "Race Category" if you are not able to report using the Federal 2 Question Format
Comments on Data:

** Age, Gender, Race/Ethnicity for Supported Housing not available at this time. The Division has applied for a continuation of its Data Infrastructure Grant which will address the collection of these data over the next 3 years.

Table 17

Table 17: ADULTS WITH SERIOUS MENTAL ILLNESS RECEIVING SPECIFIC SERVICES DURING THE YEAR

State	FY 2003					
Reporting Year	NJ					
	ADULTS WITH SERIOUS MENTAL ILLNESS					
	Receiving Family Psychoeducation	Receiving Integrated Treatment for Co-occurring Disorders (MH/SA)	Receiving Illness Management and Recovery Skills			
Age						
18-20						
21-64		Data not available *	Data not available *			
65-74						
75+						
Not Available						
TOTAL	3,912					
Gender	Data not available *	Data not available *	Data not available *			
Female						
Male						
Race	Data not available *	Data not available *	Data not available *			
American Indian/ Alaskan Native						
Asian						
Black/African American						
Hawaiian/Pacific Islander						
White						
Hispanic*						
More than one race						
Other						
Unknown						
Hispanic/Latino Origin						
Hispanic/Latino Origin						
Non Hispanic/Latino						
Hispanic/Latino Origin Not Available						
Do You Monitor Fidelity for this Service?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

IF YES,

Use?			
Who Measures Fidelity?	Providers		
How often is Fidelity Measured?	Annually		

* Only Report Hispanic as part of the "Race Category" if you are not able to report using the Federal 2 Question Format

* Hispanic is part of the total served. Yes ☒ No ☐

Comments on Data:

* The Division has applied for continuation of its Data Infrastructure Grant which will address the collection of these data over the next 3 years.

Table 11: Summary Profile of Client Evaluation of Care

Table 11			
Year Survey was Conducted		2003	
State Identifier:		NJ	
Adult Consumer Survey Results:	Number of Positive Responses	Responses	Confidence Interval*
1. Percent Reporting Positively About Access.	395	453	
2. Percent Reporting Positively About Quality and Appropriateness for Adults	351	436	
3. Percent Reporting Positively About Outcomes.	306	414	
4. Percent of Adults Reporting on Participation In Treatment Planning.	319	441	
5. Percent of Adults Positively about General Satisfaction with Services.	402	462	
Child/Adolsecent Consumer Survey Results:	Number of Positive Responses	Responses	Confidence Interval*
1. Percent Reporting Positively About Access.	63	81	
2. Percent Reporting Positively about General Satisfaction for Children.	45	64	
3. Percent Reporting Positively about Outcomes for Children.	164	249	
4. Percent of Family Members Reporting on Participation In Treatment Planning for their Children	341	504	
5. Percent of Family Members Reporting High Cultural Sensitivity of Staff. (Optional)	569	704	
<i>* Please report Confidence Intervals at the 95% level. See directions below regarding the calculation of confidence intervals.</i>			
State Comments on Data:		Survey of all consumers of Assertive Community Treatment were distributed November 2003. Analysis will be reported in the next annual report. Child/Adolsecent Consumer Survey Results are preliminary.	

Adult Consumer Surveys

1. Was the Official 28 Item MHSIP Adult Outpatient Consumer Survey Used?

☐ Yes

☒ No

1.a. If no, which version:

1. Original 40 Item Version ☐ Yes

2. 21-Item Version ☐ Yes

3. State Variation of MHSIP ☒ Yes

4. Other Consumer Survey ☐ Yes

1.b. If other, please attach instrument used.

1.c. Did you use any translations of the MHSIP into another language?

☒ 1. Spanish

2. Other Language:

Adult Survey Approach:

2. Populations covered in survey? (Note all surveys should cover all regions of state)

☐ 1. All Consumers in State

☒ 2. Sample of MH Consumers

2.a. If a sample was used, what sample methodology was used?

- ☐ 1. Random Sample
☐ 2. Stratified Sample
☐ 3. Convenience Sample

4. Other Sample:

2.b Do you survey only people currently in services, or do you also Survey Persons no longer in service?

- ☒ 1. Persons Currently Receiving Services
☐ 2. Persons No Longer Receiving Services

3. Please Describe the populations included in your sample: (e.g., all adults, only adults with SMI, etc.)

- ☐ 1. All Adult consumers in state
☒ 2. Adults with Serious Mental Illness
☐ 3. Adults who were Medicaid Eligible or in Medicaid Managed Care

3.4 Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

4. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Mail	<input checked="" type="checkbox"/> Yes	
Face-to-face		<input type="checkbox"/> Yes
Web-Based	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

4.b. Who administered the Survey? (Check all that apply)

- ☐ 1. MH Consumers
☐ 2. Family Members
☐ 3. Professional Interviewers
☐ 4. MH Clinicians
☐ 5. Non Direct Treatment Staff

6. Other: describe:

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?

- ☐ 1. Responses are Anonymous
☒ 2. Responses are Confidential
☐ 3. Responses are Matched to Client databases

6. Sample Size and Response Rate

6a. How many Surveys were Attempted (sent out or calls initiated)?

6.b How many survey Contacts were made? (surveys to valid phone numbers or addresses)

6.c How many surveys were completed? (survey forms returned or calls completed)

6.d. What was your response rate? (number of Completed surveys divided by number of Contacts)

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these survey's as "completed" for the calculation of response rates?

1600
1592
595
29%

☐ Yes ☒ No

7. Who Conducted the Survey

7.a. SMHA Conducted or contracted for the Survey (survey done at state level)

☐ Yes ☐ No

7.b. Local Mental Health Providers/County mental health providers conducted or contracted for the survey (survey was done at the local or regional level)

☒ Yes ☐ No

7.c. Other: Describe:

* Report Confidence Intervals at the 95% confidence level

Note: The confidence interval is the plus-or-minus figure usually reported in newspaper or television opinion poll results. For example, if you use a confidence interval of 4 and 47% percent of your sample picks an answer you can be "sure" that if you had

The confidence level tells you how sure you can be. It is expressed as a percentage and represents how often the true percentage of the population who would pick an answer lies within the confidence interval. The 95% confidence level means you can be 95%

When you put the confidence level and the confidence interval together, you can say that you are 95% sure that the true percentage of the population is between 43% and 51%. (From www.surveysystem.com)

Child/Family Consumer Surveys

1. Was the MHSIP Children/Family Survey (YSS-F) Used?

If no, please attach instrument used.

☐ Yes ☒ No

1.c. Did you use any translations of the Child MHSIP into another language?

☐ 1. Spanish

2. Other Language:

Child Survey Approach:

2. Populations covered in survey? (Note all surveys should cover all regions of state)

- ☐ 1. All Consumers in State
☒ 2. Sample of MH Consumers

2.a. If a sample was used, what sample methodology was used?

- ☒ 1. Random Sample
☐ 2. Stratified Sample
☐ 3. Convenience Sample
 4. Other Sample:

2.b Do you survey only people currently in services, or do you also Survey Persons no longer in service?

- ☒ 1. Persons Currently Receiving Services
☒ 2. Persons No Longer Receiving Services

2a. If yes to 2, please describe how your survey persons no longer receiving services.

3. Please Describe the populations included in your sample: (e.g., all children, only children with SED, etc.)

- ☐ 1. All Child consumers in state
☐ 2. Children with Serious Emotional Disturbances
☐ 3. Children who were Medicaid Eligible or in Medicaid Managed Care

3.4 Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

Children and parents/care givers 13 years or older

4. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Mail	<input checked="" type="checkbox"/> Yes	
Face-to-face		<input type="checkbox"/> Yes
Web-based	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

4.b. Who administered the Survey? (Check all that apply)

- ☐ 1. MH Consumers
☐ 2. Family Members
☐ 3. Professional Interviewers
☐ 4. MH Clinicians
☐ 5. Non Direct Treatment Staff

6. Other: describe: Self Administered

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?

- ☒ 1. Responses are Anonymous
☒ 2. Responses are Confidential
☐ 3. Responses are Matched to Client databases

6. Sample Size and Response Rate

6a. How many Surveys were Attempted (sent out or calls initiated)?

3700 youth & 3700 caregivers/parents

6.b How many survey Contacts were made? (surveys to valid phone numbers or addresses)

6.c How many surveys were completed? (survey forms returned or calls completed)

6.d. What was your response rate? (number of Completed surveys divided by number of Contacts)

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these survey's as "completed" for the calculation of response rates?

3,700
106
3%*

☐ Yes ☒ No**7. Who Conducted the Survey**

7.a. SMHA Conducted or contracted for the Survey (survey done at state level)

☒ Yes ☐ No7.b. Local Mental Health Providers/County mental health providers conducted or contracted for the survey
(survey was done at the local or regional level)☐ Yes ☐ No

7.c. Other: Describe:

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*Reflects preliminary response rate.

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Table 20A Non-Forensic (Voluntary and Civil-Involuntary Patients)

READMISSION TO ANY STATE PSYCHIATRIC INPATIENT HOSPITAL WITHIN 30/180 DAYS OF DISCHARGE					
State	NJ				
Reporting Year	June 1,2003 to May 31,2004				
Age	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	3010	266	603	8.84%	20.03%
0-3					
4-12	7			0.00%	0.00%
13-17	90	4	11	4.44%	12.22%
18-20	141	9	22	6.38%	15.60%
21-64	2503	244	549	9.75%	21.93%
65-74	115	8	17	6.96%	14.78%
75+	120	1	4	0.83%	3.33%
Not Available					
Gender					
Female	1215	90	233	7.41%	19.18%
Male	1795	176	370	9.81%	20.61%
Gender Not Available					
Race					
American Indian/ Alaskan Native	3	3	3	100.00%	100.00%
Asian	43	2	5	4.65%	11.63%
Black/African American	852	87	203	10.21%	23.83%
Hawaiian/Pacific Islander					
White	1825	156	344	8.55%	18.85%
Hispanic*	259	17	43	6.56%	16.60%
More than one race					
Other	24	1	5	4.17%	20.83%
Race Not Available	4			0.00%	0.00%
Hispanic/Latino Origin					
Hispanic/Latino Origin	259	17	43	6.56%	16.60%
Non Hispanic/Latino	2747	249	560	9.06%	20.39%
Hispanic/Latino Origin Not Available	4	0	0	0.00%	0.00%

* Only Report Hispanic as part of the "Race Category" if you are not able to report using the Federal 2 Question Format

Are Forensic Patients Included? ☐ Yes ☐ No

Comment:

Contiguous transfers between State Psychiatric facilities are not included.

NJ combines Asian/Pacific Islander in its race/ethnicity MIS category, so Pacific Islanders are reported under the Asian category.

NJ does not use multiple race categories.

TABLE 1

**DMHS Funded Community Care Services: Evaluation
Data Episodes of Care**

Community Services		Estimated SFY '04	Projected SFY '05	Projected SFY '06	Projected SFY '07
Emergency Service	Adult	88,943	89,832	90,731	91,638
	Children	13,526	13,661	13,798	13,936
	Total	102,469	103,494	104,529	105,574
Outpatient Services	Adult	135,624	136,980	138,350	139,734
	Children	23,090	23,321	23,554	23,790
	Total	158,714	160,301	161,904	163,523
Partial Care	Adult	10,915	10,915	10,915	10,915
	Children	2,528	2,528	2,528	2,528
	Total	13,443	13,443	13,443	13,443
Residential					
	Licensed Residential	2,460	2,485	2,509	2,535
	Licensed Residential(child)	369	373	376	380
	Non-DMHS Licensed	650	657	663	670
	Non-DMHS Licensed(child)	78	79	80	80
	Total	3,557	3,593	3,628	3,665
Systems Advocacy					
	Legal Services	3,621	3,621	3,621	3,621
	Community Advocacy	172	172	172	172
	Total	3,793	3,793	3,793	3,793
Evidence Based Practices*					
	PACT	1,840	1,984	2,039	2,094
	IFSS	3,443	3,477	3,512	3,547
	Supported Employment	1,637	1,653	1,670	1,687
	Supportive Housing	1,600	1,650	1,700	1,750
	Total	5,080	8,765	8,921	9,078
CaseManagement					
	Integrated Case Management	10,990	11,100	11,211	11,323
	Youth Case Management	2,719	2,746	2,774	2,801
	Total	13,709	13,846	13,985	14,124
PATH		6,000	6,060	6,121	6,182
Consumer Operated Self Help Centers		11,017	11,128	11,239	11,351
Total Episode of Care		317,782	324,422	327,562	330,733

*Additional evidenced based practices as being implemented, e.g. medication algorithms, co-occurring substance abuse and mental illness, etc. which are expected to be monitored and evaluated as the data infrastructure systems are enhanced.

ACCESS INDICATOR

Goal 1: **Ensure that mental health consumers and their families are satisfied with the services they receive.**

Objective: Measure client perception of care through annual evaluation surveys.

Population: Adults diagnosed with a serious and persistent mental illness.

Criterion: *Comprehensive Community Based Mental Health System*

Brief Name: Maintain consumer satisfaction.

Indicator: Maintain percent of consumers who report satisfaction with mental health services provided.

Measure: Comparison of annual survey results.

Sources of Information: Consumer satisfaction surveys using modified MHSIP survey.

Special Issues: The New Jersey Division of Mental Health Services consistently strives to ensure that consumers of mental health services provide input into all aspects of mental health care ranging from the policy and planning perspective to the direct provision of services.

Significance: Information regarding consumer perception of care is vital for program planning and improvement and to ensure that services provided continually move consumers toward positive outcomes.

SFY '04	FY '05	FY '06	FY '07
<u>Baseline</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>

Access Indicator

- Maintain percent of consumer satisfaction.**

Value:	<u>87%</u>	<u>87%</u>	<u>87%</u>	<u>87%</u>
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ACCESS INDICATOR

Goal 2: **Ensure access to community based services for persons with serious mental illness.**

Objective: Continue to provide Integrated Case Management Services to adults discharged from a State or County hospital and to persons with multiple admissions to the short term care facilities.

Population: Adults diagnosed with a serious and persistent mental illness.

Criterion: *Comprehensive Community Based Mental Health System*

Brief Name: Access to Integrated Case Management

Indicator: Number of persons receiving Integrated Case Management Services.

Measure: Total number of persons served by ICMS annually.

Sources of Information: Division's Quarterly Contract Monitoring (QCMR) system.

Special Issues: Integrated Case Management Services are provided for a minimum of 18 months to persons discharged from a state or county hospital. In support of Redirection II, these services are now available to persons with multiple hospitalizations within a 12 month period to a short- term care facility.

Significance: Integrated Case Management Services provide an array of clinical and support services designed to reintegrate consumers hospitalized in a State, County or STCF hospital into the community of their choice, to link consumers with community mental health services, and to assist persons with serious mental illness to remain in the community. ICMS accomplishes this by assessing each consumer's needs, facilitating linkages to mental health, financial and non-mental health resources and monitoring the consumer's engagement into this resource. Although services may vary according to clinical need, the average caseload size for ICMS is 1 case manager for 20-25 consumers.

SFY '04	FY '05	FY '06	FY '07
<u>Baseline</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>

Access Indicator

**2. Number receiving
Integrated Case
Management**

Value:	<u>10,990</u>	<u>11,100</u>	<u>11,211</u>	<u>11,323</u>
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APPROPRIATENESS/ QUALITY INDICATOR

Goal 3:	Increase access to innovative community based services for persons with serious mental illness.
Objective:	Increase use of PACT services by persons with serious mental illness.
Population:	Adults with serious mental illness.
Criterion:	<i>Comprehensive Community Based Mental Health System</i>
Brief Name:	Access to PACT.
Indicator:	Number of consumers actively enrolled in PACT.
Measure:	Comparison of number of people served over a three-year period (based on sum of ending caseload for prior FY and total enrolled for subsequent year)
Sources of Information:	PACT monthly report.
Special Issues:	PACT services were introduced to New Jersey as a result of the first Redirection Plan culminating in the closure of a state psychiatric hospital and expansion/enhancement of community support services. In 2001, additional programs were added and existing programs expanded to ensure statewide access of PACT services. In the Spring of 2004, the Division awarded funds to expand 3 pilot teams and enrollment of 45-47 additional clients
Significance:	The increase and enhancement of PACT services promotes access to support services in the community and promotes diversion from or reduction in psychiatric hospital re-admissions.

SFY '04	FY '05	FY '06	FY '07
<u>Baseline</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>

Appropriateness Indicator**3. Number of consumers actively enrolled in PACT**

Value:	<u>1840</u>	<u>1984</u>	<u>2039</u>	<u>2094</u>
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ACCESS INDICATOR

Goal 4: **Ensure that persons with serious mental illness have access to Supported Employment Services.**

Objective: Increase the number of persons receiving supported employment services (SEP).

Population: Adults with serious mental illness who are assessed as appropriate for SEP.

Criterion: *Comprehensive Community Based Mental Health System*

Brief Name: Access to SEP.

Indicator: Number of people receiving SEP.

Measure: Comparison of number of people receiving SEP over a three-year period.

Sources of Information: SEP Quarterly Contract Monitoring System

Special Issues: The Division is focusing resources on assuring that employment for all mental health consumers is considered and, where appropriate, supported. As one of the evidence based practices, Supported Employment (SE) for persons with mental illness has demonstrated success in employment outcomes. SE for persons with mental illness is available in every county in New Jersey.

Significance: Obtaining and maintaining gainful employment is instrumental to individual self esteem and health. It is expected that supported employment services will provide the needed supports to assist people who have serious mental illness to overcome the barriers that prevent them from maintaining employment.

SFY '04	FY '05	FY '06	FY '07
<u>Baseline</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>

Access Indicator**4. Number of people receiving SEP**

Value:	<u>1637</u>	<u>1653</u>	<u>1670</u>	<u>1687</u>
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ACCESS INDICATOR

- Goal 5:** Ensure that families of mental health consumers are provided support services to assist them to manage the day-to-day issues that affect their quality of life.
- Objective:** Provide Intensive Family Support Services (IFSS) to families of mental health consumers.
- Population:** Families of adults with serious mental illness.
- Criterion:** *Comprehensive Community Based Mental Health System*
- Brief Name:** Access to IFSS.
- Indicator:** Number served in IFSS programs.
- Measure:** Comparison of number of users over a three- year period.
- Sources of Information:** DMHS Unified Services Transaction Form (USTF)
- Special Issues:** IFSS have been a priority for DMHS and were expanded to all counties of the state in the year 2000.
- Significance:** The likelihood that consumers of mental health services will be able to live successfully in the community is greatly enhanced by families who can provide support when needed as appropriate.

FY '04	FY '05	FY '06	FY '07
<u>Baseline</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>

Access Indicator**5. Number served
In IFSS programs**

Value:	<u>3433</u>	<u>3477</u>	<u>3512</u>	<u>3547</u>
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ACCESS INDICATOR

Goal 6: **Ensure people who have serious mental illness have the support services they need to remain in the community.**

Objective: Increase the number of mental health consumers who have access to Supportive Housing services.

Population: People who have serious mental illness.

Criterion: *Comprehensive Community Based Mental Health System*

Brief Name: Access to Supportive Housing services.

Indicator: Number accessing Supportive Housing.

Measure: Comparison of number of users over a three- year period.

Sources of Information: DMHS QCMR data base.

Special Issues: Supportive Housing is designed to ensure consumers of mental health services have a choice of permanent, safe and affordable housing that is not contingent on participation in traditional mental health programs.

Significance: The likelihood that consumers of mental health services will be able to live successfully in the community is greatly increased by the provision of Supportive Housing services.

SFY '04	FY '05	FY '06	FY '07
<u>Baseline</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>

Access Indicator**6. Number accessing
 Supportive Housing**

Value:	<u>1600</u>	<u>1650</u>	<u>1700</u>	<u>1750</u>
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ACCESS INDICATOR

Goal 7: **Ensure that adults with Serious Mental Illness are served in community settings whenever possible.**

Objective: Reduce the number of admissions and re-admissions to State Psychiatric Hospitals.

Population: Adults with serious mental illness.

Criterion: *Comprehensive Community Based Mental Health System*

Brief Name: Reduce re-admissions.

Indicator: Number of persons discharged from state hospitals readmitted within 30 days and 180 days.

Measure: Comparison of re-admissions over a three- year period.

Sources of Information: DMHS hospital-wide census data base.

Special Issues: The community mental health system continues to evolve, providing more opportunities for adults with serious mental illness to be served and supported in their communities.

Significance: The expansion and enhancement of acute care and diversionary services in local communities reduces reliance on more restrictive settings.

	SFY '04 <u>Baseline</u>	FY '05 <u>Target</u>	FY '06 <u>Target</u>	FY '07 <u>Target</u>
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Access Indicator**7. Number of re-Admissions**

Value 30 days:	<u>266*</u>	<u>260</u>	<u>255</u>	<u>250</u>
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Value 180 days:	<u>603*</u>	<u>600</u>	<u>595</u>	<u>590</u>
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*refer to table 20A on page 36.

ADDITIONAL DESCRIPTION OF COMMUNITY BASED MENTAL HEALTH SERVICES

Consumer-Managed Services

Over the past decade consumers have had an ever-increasing role in partnering with the Division to improve the quality of community mental health services. Since 1993 they have participated in site reviews of community mental health agencies conducted by the Office of Licensing – Mental Health, as well as numerous work groups convened to develop the licensing standards on which the reviews are based. Consumers have provided input on major Division initiatives through participation in statewide and regional advisory groups established by the Division Director to address key operational and policy concerns such as the Division's Statewide Advisory Committee and ongoing subcommittees to guide the first Redirection Plan (1995 – 1998); and more recently Redirection II (2002 to present). They also provide regional and state level input into program design and actively participate in the application review process in response to Requests for Proposals. The efforts to include consumers in policy forums have now become "standard operating procedure" throughout the public mental health system. Consumers are members of all county mental health boards, on the State Mental Health Board and Planning Council, on the Assessment and Planning Advisory Committee for Redirection II, and other committees. In addition, consumers have made a tremendous contribution as providers on PACT Teams, with a requirement for Peer Advocates on the teams incorporated in DMHS regulations, and as ICMS case managers and in other roles throughout the public mental health system.

There are five statewide consumer-run organizations: Collaborative Support Programs of New Jersey (CSP-NJ); Coalition of Mental Health Consumer Organizations (COMHCO); The Consumer Provider Association in New Jersey, the Consumer Advocacy Partnership, and Consumer Connections. CSP-NJ provides direct services including self-help centers, peer support services, supportive housing, and consultation to self-help groups. The main emphasis within the Coalition of Mental Health Consumer Organizations (COMHCO) is on consumer advocacy initiatives. It is a statewide membership organization that advocates for individual rights and consumer involvement and leadership in the mental health system. Also, COMHCO hosts an annual consumer conference which is attended by over 300 consumers.

Consumer Connections is a comprehensive program managed by consumers through the Mental Health Association of New Jersey and Collaborative Support Programs of New Jersey. It is a nationally recognized program designed to recruit, train and support consumers of mental health services who are seeking to be providers of mental health services.

In the year 2000, with the support of a grant from SAMHSA, the Consumer Provider Association in New Jersey officially organized with the support of the Division of Mental Health Services and the Mental Health Association in New Jersey (MHANJ). This 150 member strong organization of consumer providers and supports is a national model of mutual support and advocacy surrounding consumers in the workplace. This is representative of the success of the consumer provider movement in New Jersey.

In 2001, the Mental Health Association in NJ (MHANJ) and Collaborative Support Services of NJ (CSPNJ) formed the Consumer Advocacy Partnership, along with COMHCO and the Consumer Provider Association (CSPNJ), in order to work together to identify important system issues that impact the lives of mental health consumers and to create opportunities for consumers to effect systems change. The partnership actively builds consumer leadership by training consumers and preparing them to be integrated into advocacy efforts statewide.

New Jersey Self-Help Group Clearinghouse

The Self-Help Clearinghouse was created by the DMHS as the first such statewide clearinghouse in the country. For the last twenty three years, the increased use and development of local self-help support groups has been an integral part of New Jersey's system of community mental health services. Self-help support groups play a key role in preventing a wide variety of stressful life problems from intensifying to the point where they require professional treatment. The groups supplement treatment through peer support and empowering assistance not available within the professional milieu. The Clearinghouse continues to work closely with other New Jersey consumer and family organizations, such as Collaborative Support Programs of New Jersey, the NAMI-NJ, and the New Jersey Parents Caucus.

Family Support Initiatives

NAMI of New Jersey is an organization that has developed and currently operates a wide range of support, education and advocacy services to families of persons with mental illness. The organization sponsors anti-stigma activities through its National End Discrimination Campaign in New Jersey. Thousands of pieces of literature have been distributed statewide as well as presentations and other educational activities to promote knowledge and eliminate stigma against people who have serious mental illness.

NAMI NJ has at least one affiliate in every county and, additionally, a Spanish affiliate in Hudson; an affiliate at Greystone Park Psychiatric Hospital in Morris; and a South Asian affiliate, bringing the total affiliates to 24 in all counties of the State.

Supported by the DMHS, the NAMI NJ Family-to-Family education program (formerly Journey of Hope), the Expressive Arts Network, the Volunteers in Service to America program, the Wall of Words and implementation of the Family Support Plan are among the numerous activities that NAMI NJ undertakes as part of their anti-stigma campaign and family support initiatives. The NAMI NJ Family-to-Family Education program provides a well-developed family education and self-help support program to families and friends of individuals who have been diagnosed with a mental illness. The initial implementation of the program involves intensive weekend training of eight two-person teams to teach the education course. These "family educator" teams then return to their respective communities to offer the 12-week course. NAMI NJ also coordinates training for Intensive Family Support Services staff and affiliate leadership.

Additionally under authority of P.L.1995C.314, NAMI NJ has been designated to prepare and monitor a "New Jersey State Family Support Plan" which, through a participatory process, enumerates goals and objectives for meeting the needs of families of persons with serious mental illness throughout the state.

Special Populations

Persons with serious mental illness are the primary target population for Division funded services, however, the Division also prioritizes services to persons with special access needs, including older adults, ethnic and linguistic minorities, and individuals with co-occurring mental health and substance abuse problems, hearing impairment, developmental disabilities, AIDS/HIV+, and criminal justice involvement. Many of the Division's activities focus on inter-organizational coordination and collaboration to improve access by special needs populations. This is achieved through interface with the various Divisions within the Department of Human Services including the Division of Developmental Disabilities, the Division of Deaf and Hard of Hearing, the Division of Family Development (welfare), Division of Youth and Family Services, the Division of Addiction Services (which became a part of DHS in April 2004) and the Division of Medical Assistance and Health Services. In addition there is coordination with the Department of Health and Senior Services, and the Department of Community Affairs (housing/homeless) and the New Jersey Housing and Mortgage Financing Agency. There is also coordination with the Division of Vocational Rehabilitation Services within the Department of Labor; and with the Department of Corrections.

In response to issues associated with individuals with mental illness who are incarcerated in municipal and county jails and state prisons, DMHS funded three pilot proposals from community mental health organizations to foster and/or strengthen community partnerships and linkages between mental health providers and the criminal justice system. They were designed to assist with community re-entry of offenders who have a serious mental illness. Each organization was funded with Federal Block Grant moneys with the objective of not only better serving the target population of persons with mental illness involved with the criminal justice system in specific counties, but also to demonstrate and better understand what services are effective. As a result, a comprehensive evaluation is being conducted by the Center for Mental Health and Criminal Justice Research at Rutgers University to assess the specific services provided by each program. DMHS expects to learn from those pilot programs and build on those areas found to be effective in reducing further involvement with the criminal justice system.

Vocational Rehabilitation

In the areas of vocational rehabilitation and employment services, DMHS funds 82 adult partial care programs in the State, and maintains 21 county-wide Supported Employment programs (serving all 21 counties). Partial care programs provide a range of pre vocational and rehabilitation services, including skill development, pre-vocational work units, career and work exploration, job seeking skills, volunteer jobs, and transitional employment. Collaboration with the state's Medicaid Division led to new Medicaid regulations for partial care that clarify what services are considered pre-vocational and encourages partial care providers to deliver these services to better prepare consumers to explore and enter the workforce.

The Division of Mental Health Services in coordination with the Division of Vocational Rehabilitation Services (DVRS) is entering its seventeenth year of providing Supported Employment services. Supported Employment (SE) programs assist consumers into integrated competitive employment opportunities. In addition to \$1.3 million provided by DVRS, an additional \$1.3 million was made available by DMHS and a funding allocation strategy developed for prioritizing extended support services; the establishment of interactive internship programs to help consumers choose

occupations; and additional job coaching services that would lead to employment. These SE programs continue in all counties for a total of 22 programs serving 615 new consumers per year. Although, the numbers of new enrollees and those served annually has remained relatively static during the past several years, DMHS continues to enhance the quality of these practices by program monitoring, staff training in new strategies and technologies and supporting SE staff and supervisors through regular network meetings. Quality and efficiency is also being supported by the implementation of a new management information system called GEMMA (General Employment Management and Marketing Application) which will allow for electronic recording, evaluating and reporting of demographic, service and contract information.

To raise the visibility of vocational/employment issues within the New Jersey public mental health system, the Division funded two Employment Resource Institutes in March of 2001. These Institutes act as employment-related experts. They provide direct vocational and employment services to adults with serious mental illness to assist them into employment as well as deliver technical assistance and training to consumers, family members, practitioners and community provider program leaders in employment best practices. The Institutes link with the existing self-help centers, Supported Employment (SE) programs in each county, local Division of Vocational Rehabilitation Offices and Department of Labor's One-Stop Career Centers, PACT teams and other mental health and rehabilitation services. The direct employment services are expected to be mobile, delivered to the consumer where they may congregate rather than being office or facility bound. The services complement existing employment services such as SE and serve those who might otherwise not participate in the workforce. Through September 2003, 225 individuals with mental illness have received vocational services, 525 consumers received critical employment information through seminars, 1,035 staff received training and 50 agencies have received technical assistance to enhance their employment related services.

The Division of Mental Health Services (DMHS) and the Division of Family Development (DFD) launched a collaborative initiative to target special services for hard to serve TANF (Temporary Assistance to Needy Families) recipients who were suspected of experiencing psychiatric difficulties. The purpose of the Welfare to Work - Mental Health Initiative (MHI) is to identify, assess and provide essential mental health and job readiness services to enable TANF recipients with significant mental health issues to enter the workforce. The initiative, which began as a pilot project in Atlantic County, was expanded to include five additional large urbanized counties that in total serve 76% of the state's welfare population.

County Welfare Agency staff refers TANF recipients suspected of having significant mental health issues to a clinically trained mental health case manager employed by a local agency. The case manager verifies a mental illness diagnosis and identifies and arranges for mental health services needed by the recipient which might include a psychiatric evaluation and medication, outpatient counseling or partial care/psychosocial rehabilitation services. Unless full time mental health services are needed, the TANF recipient will also begin job readiness and employment services provided by employment specialists employed by another provider. Employment services may include vocational readiness determination, career profiling, community based occupational exploration, job seeking skills, alternative work experience with support, support plan development, individualized job placement, and ongoing employment support. The mental health case manager and employment specialists operate as a single welfare to work team and are physically located together. Each

county team works with 100 TANF recipients annually for a total of 600, although they may screen and assess up to twice as many recipients.

Housing

DMHS supports a range of housing options from independent living to 24 hour supervised residential programs, which support community rather than institutional living for persons with serious mental illness. Prior to the first Redirection Plan, the Division funded 1,916 beds with supported services. As a result of the first Redirection Plan and the Redirection II Plan now being implemented, DMHS provides 2,261 licensed supervised beds and 1,600 supportive housing spaces. In all of the Division's residential programs, the goal is to encourage the creative coupling of support services funding with capital or housing program funds such as HUD Section 8 rental vouchers, Department of Community Affairs programs, Housing and Mortgage Finance Agency support, Public Housing Authorities, Division bond funds, and other mainstream housing resources.

Over recent years, the Division also increased the availability and range of other community living options for persons with serious mental illness. Included were \$24 million in bond funds to support capital projects; cooperation with the Department of Health and Senior Services and the Department of Community Affairs to further address the problems of persons with serious mental illness living in substandard boarding homes; and a unique statewide collaboration among State mental health and housing authorities and private and not-for-profit mental health and housing organizations regarding housing policies which support community living for persons with serious mental illness.

The Supportive Housing Association, a group of mental health consumers, family members, agencies, State and local housing providers, was formed in 1996 and incorporated in 1997, to encourage the development of supportive housing opportunities in the state for people with mental illness. The Association has continued to meet and has focused its efforts on defining supportive housing, and obtaining information on other states' experiences with this model and research/studies that have been conducted. It has attracted more than 35 agencies in New Jersey and continues to advocate for supportive housing, including technical assistance to organizations interested in developing this program. Technical assistance is provided to over 50 mental health community agencies on a quarterly basis.

Together with the Department of Community Affairs, the Division began working with the Corporation For Supportive Housing (CSH) to increase permanent housing for individuals with special needs who are living in institutions or substandard housing, and who are homeless or at at-risk of homelessness. The Division, the Department of Community Affairs, and the Housing Mortgage Financing Agency reached a formal agreement with the Corporation for Supportive Housing and each contributed \$100,000 to increase supportive housing in the state. CSH also contributed significant resources of its own to this initiative. A CSH office is established in Trenton staffed by a Project Director.

CSH has been a strong technical assistance provider and resource for non-profit and government agencies in New Jersey since its inception in July 1997. CSH has assisted with the development of nearly 850 supportive housing units providing loans totaling approximately \$ 3.0 million. CSH provides financial support (pre-development loans and grants) and works with sponsor development teams on

issues such as design, zoning, financing, and service planning. The Corporation for Supportive Housing co-hosts the annual Supportive Housing Conference in conjunction with the Supportive Housing Association of New Jersey and provides trainings and workshops throughout the year on practical and policy aspects of supportive housing development and operations.

CSH also provides staff support to the Supportive Housing Association of New Jersey and the New Jersey Alliance for the Homeless. With the help of CSH, over 400 supportive housing units are in operation, construction or renovation. Approximately 300 units are in pre-development or early concept planning phases. CSH has also assisted sponsors in developing projects ranging from a single family home for three adults with serious mental illness to a 131-unit apartment building. CSH provides financial support (pre-development loans and grants) and works with sponsor development teams on design, finance, program outline, and other areas. Since its inception in July 1997, the New Jersey CSH program has provided over \$1.4 million in grants and loans to Supportive Housing providers and has facilitated the investment of over \$6 million in equity funding through the syndication of low income housing tax credits from the National Equity fund.

Integrated Case Management

Originally begun as part of its first Redirection Plan the Division of Mental Health Services (DMHS) reorganized case management services and expanded them to provide a minimum of 18 month follow-up to all consumers discharged from state and county psychiatric hospitals. Since then, the staffing devoted to ICMS was increased, thereby increasing access to ICMS for persons with frequent Short Term Care Facility (STCF) hospitalizations. The clinical and administrative barriers between the former liaison services, adult clinical and 450 case management were eliminated, and a single integrated case management system was created. This was accomplished by consolidating liaison and case management resources, and adding substantial new funding to expand this enhanced case management service in all 21 counties.

These enhanced services are provided to people discharged from any of the adult state and county hospitals and to individuals referred from within their local acute care system. At any one time, the number of consumers receiving ICMS services now totals over 6,200, with the average caseload size of one case manager to 20-25 consumers.

Although it is expected that most people will receive significantly more hours of service as they make the transition from inpatient to community based treatment, a minimum of four hours of face-to-face contact is mandated within the first 60 days. The intensity of additional face-to-face activity throughout the 18 months is driven by assessed individual need. The Division utilizes a Risk of Hospitalization scale, proven to be reliable and valid, to guide the monthly hours of service. The scale is used for hospital discharge planning, as well as community living.

Integrated Case Management services are committed to maximizing consumer independence and functioning, while reducing the need for unnecessary state and county psychiatric inpatient care. To obtain outcomes information, DMHS program and information technology staff are working towards developing a client-specific outcomes database.

DMHS maintains a strong commitment to ensuring best practice principles drive the provision of case management services. To this end, DMHS provides significant financial support to the NJ Association of Clinical Case Management's (NJACCM) annual full-day conference. This event is structured especially to meet the professional development needs of case management staff. A strategy is being developed with NJACCM to design and implement an extensive, ongoing statewide ICMS training initiative.

PACT

As part of the Division's first Redirection Plan, New Jersey developed a new program, Programs in Assertive Community Treatment (PACT), to serve the high hospital readmission population, who are not diverted by Integrated Case Management and other similarly intensive mental health services.

Thirty one PACT teams are now serving consumers in 21 counties. In December, 2003, the Division initiated a pilot program in three counties with high admission rates (Union, Mercer, Ocean) in order to step-down consumers within their respective teams who have achieved stability, and enroll 45-47 additional consumers. The phase-in of these new enrollees is expected to be completed during FY05. As of March 31, 2004, 2,702 individuals had been enrolled in PACT services statewide at one time or another. A total of 1,777 remain actively participating, representing a retention rate of 62%. Since DMHS PACT regulations allow PACT providers to discharge people who have been hospitalized or incarcerated for 6 continuous months with no imminent discharge or release date, this high retention rate is extremely significant for a group of consumers who have historically failed to maintain contact with traditional mental health programs and have been high users of more costly Division-funded inpatient and acute care services.

The contracted outcomes for PACT are a 50% reduction in state hospital admissions and ensuring that no more than one third of the active caseload is hospitalized in any quarter. These targets have been consistently met and often exceeded since the program's inception.

PACT consumers report that the program has made a difference in their lives. In December 2003, the Division conducted its second federally funded statewide PACT consumer survey. Preliminary results from 403 consumers who have completed the survey (25% of statewide caseload) indicate a positive assessment of the program, with a mean of 8.4 on a scale of 1 to 10, with 10 being excellent.

Public Information and Outreach

DMHS has funded a total of seven providers to provide a series of programs to promote public awareness and education about serious mental illness and to target those aspects that directly bear upon adults with serious mental illness and children with serious emotional disturbances. Target populations include teachers and school aged youths ranging from middle school to college level; the media; civic groups; faith based communities; mental health consumers; ethnic minorities and employers. Activities include classroom presentations; training for consumers; integration of anti-stigma material in college curriculums; live panel presentations to schools and colleges; and production and dissemination of public services announcements, fact sheets, posters and other educational material for mass distribution in English and Spanish.

CRITERION 2

Mental Health System Data and Epidemiology

Quantitative targets to be achieved through the implementation of the mental health system, including estimates of the prevalence rates of individuals with SMI and Youth with Serious Emotional Disturbances in the state and the numbers of SMI and Youth with Serious Emotional Disturbances to be served, will be specified.

DESCRIPTION

The State has adopted the Federal definition that stipulates that adults with a serious mental illness are persons:

Age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within (DSM IV), that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. (Federal Register, Vol. 58, No. 96, May 20, 1993, p. 29425)

According to the Federal methodology proposed for estimating the prevalence of serious mental illness, the proportion of adults within the State with a serious mental illness is 5.4% or 351,366 individuals in State fiscal year 2003. Within this fairly broad group, the State gives the highest priority to persons with severe and persistent mental illness, nationally estimated at about 2.6% of the adult population, or 169,176 individuals in New Jersey.

The Division of Mental Health Services is able to determine treated prevalence within the publicly funded mental health system through its management information system. The Unified Services Transaction Form (USTF) database is a de-identified client registry for individuals seen in State and County psychiatric hospitals, short term care facilities and publicly-funded mental health program elements in community mental health agencies. A form is completed for every consumer upon admission and discharge from a public mental health service provider. The USTF was revised, effective July 1989, to be 100 percent consistent with the Mental Health Statistical Improvement Program (MHSIP) minimum data set. The USTF provides the State with information regarding treated prevalence within the public mental health system.

Among the data elements is a record of the consumer's functioning at episode admission and discharge. Since the mid-1980's, the State has used the Global Level of Functioning (GLOF) scale for this purpose. The GLOF is a modification of the scale developed by Carter and Newman (1976), and has 10 levels that provide an overall score integrating separate judgments of consumer functioning on four dimensions: personal self-care; social and interpersonal functioning; vocational and/or educational productivity; and emotional stability and stress tolerance. Lower scores indicate lower levels of functioning, with scores of 5 or less characterizing the State's priority population of persons with severe and persistent mental illness. Use of this measure to determine the proportion of persons with serious mental illness served may under-represent the numbers served as operationally defined by the Federal methodology. As a result, the State continues to review this measure to consider whether changes are appropriate.

During fiscal year 2003, the State served 253,421 unduplicated adults aged 18 or over (refer to Basic Tables 2A), of whom 96,918 or 38.2% were assessed through admission Global Level of Functioning as having serious mental illness. Of all adults served, 33.6% were unemployed, and another 33.3% were not in the labor force while 36.1% were employed. There were more women (51.9%) than men served and of all adults served 40% were minorities, primarily African-American (21.1%) and Hispanic (13.8%) refer to Basic Table 2B.

Of the SMI adults served, 51.5% were female, 11.2% were employed full-time, 38.2% were unemployed, 34.5% were not in the labor force, and 44.0% were minorities. Information regarding children is located in the children's section of the plan.

A major initiative currently underway is the clean up and migration of the USTF data system from a mainframe to a data warehouse. The new system will provide the ability to more easily create unduplicated statistics on consumers served as well as to eventually identify those consumers also receiving services from other Department of Human Services' agencies including Medicaid, welfare, child protection, et al.

In addition to the USTF, under DMHS contracting procedures, funded agencies agree to provide specified types of services for a pre-determined number of consumers. In order to monitor compliance with contractual agreements, agencies submit quarterly reports to the Division that specify actual service provision by type of services provided. The Quarterly Contract Monitoring Report (QCMR) database provides the Division with information regarding aggregate utilization and costs for contracted community program services.

An initiative will be developed to systematically review and revise QCMR data collection methods. Focus groups representing all DMHS contracted program elements will provide input to revise the QCMR. To the extent feasible the focus groups will be charged with identifying appropriate outcome measures to assess program efficacy per program element reviewed, while ensuring that requisite data collection needs are met for contract monitoring purposes.

The new stand alone MS Access USTF Database has been distributed to all agencies requiring it. There are 80 agencies currently submitting data to the Division through the use of this software. Also, the IT Project has participated in following-up with each agency to assure that their data is submitted regularly. More than 65 end users have been trained in the software, and the IT Project continues to schedule free training for agencies needing it.

This year, the software has been updated, requiring a re-release process. The IT Project is currently underway contacting agencies for on-site visits to update their databases and software. More than 160 hours are dedicated to this process.

This year, the IT Project is supporting the new GEMMA software for the Divisions' Supported Employment contracting agencies. The software was rolled out in March, 2004.

NJ - 65

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

This table provides an aggregate profile of persons in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for all such programs. Please provide unduplicated counts if possible.

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

Table 2.													
Report Year:	FY 2003 *												
State Identifier:	NJ												
	Total				American Indian or Alaska Native			Asian			Black or African American		
	Female	Male	Not Available	Total	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
0-3 Years	450	511	41	1002	7	9		3	3		77	127	
4-12 years	6,513	12,418	31	18962	54	54	1	45	91		1808	3888	7
13-17 years	10,729	13,006	57	23792	78	90		142	144		2459	3371	16
18-20 years	6,341	7,301	39	13681	47	49	1	110	81		1281	1807	3
21-64 years	115,085	97,525	607	213217	1026	918	7	1257	963	5	23426	21171	76
65-74 years	8,348	4,624	36	13008	66	41		50	41		1273	658	2
75+ years	8,800	4,288	58	13146	92	40	1	39	22	1	902	412	1
Not Available	194	171	4	369	1	1	1	2	4		39	24	1
Total	156,460	139,844	873	297177	1,371	1,202	11	1,648	1,349	6	31,265	31,458	106

* Fy '04 USTF data(demographics) not available at this time.

Comments on Data:

NJ combines Asian/Pacific Islander in its race/ethnicity MIS category, so Pacific Islanders are reported under the Asian category.
 NJ does not use multiple race categories.
 Database is unduplicated across entire service system.

NJ - 66

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

This table provides an aggregate profile of persons in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for all such programs. Please provide unduplicated counts if possible.

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

Table 2.									
Report Year:	FY 2003 *								
State Identifier:	NJ								
	Native Hawaiian or Other Pacific			White			Hispanic * use only if data for Table		
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
0-3 Years				271	246	1	75	110	1
4-12 years				2984	5041	6	1331	2771	
13-17 years				5821	6311	18	1847	2587	6
18-20 years				3618	3851	14	1026	1290	7
21-64 years				69498	59624	278	15927	11723	63
65-74 years				5664	3197	25	1097	532	4
75+ years				7032	3482	27	496	205	3
Not Available				123	111		21	16	
Total	-	-	-	95,011	81,863	369	21,820	19,234	84

* Fy '04 USTF data(demographics) not available at this time.

Comments on Data:

NJ - 67

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

This table provides an aggregate profile of persons in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for all such programs. Please provide unduplicated counts if possible.

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

Table 2.									
Report Year:	FY 2003 *								
State Identifier:	NJ								
	More Than One Race Reported			Other Race			Race Not Available		
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
0-3 Years				14	11	25	3	5	14
4-12 years				200	399		91	174	17
13-17 years				258	355		124	148	17
18-20 years				161	158		98	65	14
21-64 years				2450	2104	14	1501	1022	164
65-74 years				114	86	1	84	69	4
75+ years				126	76	1	113	51	24
Not Available				1	2		7	13	2
Total	-	-	-	3,324	3,191	41	2,021	1,547	256

* FY '04 USTF data(demographics) not available at this time.

Comments on Data:

NJ - 68

Table 2B. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

Of the total persons served, please indicate the age, gender and the number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons served would be the total as indicated in Table 2A.

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

Table 2.													
Report Year:	FY 2003												
State Identifier:	NJ												
	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Not Available			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
0 - 3 Years	372	396	26	75	110	1	3	5	14	450	511	41	1,002
4 - 12 years	5091	9473	14	1331	2771		91	174	17	6,513	12,418	31	18,962
13 - 17 years	8758	10271	34	1847	2587	6	124	148	17	10,729	13,006	57	23,792
18 - 20 years	5217	5946	18	1026	1290	7	98	65	14	6,341	7,301	39	13,681
21-64 years	97657	84780	380	15927	11723	63	1501	1022	164	115,085	97,525	607	213,217
65-74 years	7167	4023	28	1097	532	4	84	69	4	8,348	4,624	36	13,008
75+ years	8191	4032	31	496	205	3	113	51	24	8,800	4,288	58	13,146
Not Available	166	142	2	21	16		7	13	2	194	171	4	369
Total	132,619	119,063	533	21,820	19,234	84	2,021	1,547	256	156,460	139,844	873	297,177

* FY '04 USTF data(demographics) not available at this time.

State Comments on Data:

NJ combines Asian/Pacific Islander in its race/ethnicity MIS category, so Pacific Islanders are reported under the Asian category.
 NJ does not use multiple race categories.
 Database is unduplicated across entire service system.

POPULATION ACCESS INDICATOR

Goal 8: **Assess utilization of mental health services by persons with serious mental illness.**

Objective: Increase the number of adults with SMI who are receiving non-emergency community mental health services.

Population: Adults with serious mental illness.

Criterion: *Estimates of Prevalence and Treated Prevalence*

Brief Name: Number of SMI adults treated.

Indicator: Unduplicated number of adults with SMI who are using non-emergency mental health services.

Measure: Unduplicated number of adults with SMI using non-emergency mental health services.

Sources of Information: Division's Client Registry.

Special Issues: As a result of the Redirection II Plan, New Jersey has increased and enhanced community support services. Additional improvements are expected and it is anticipated the number of persons receiving community mental health services will be increased and the range of services received by many persons already served will be further expanded.

Significance: Maintaining an array of community mental health support services will help to ensure continued use of community based non-emergency services and appropriate use of emergency mental health services.

SFY '04	FY '05	FY '06	FY '07
<u>Baseline</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>

Population Access Indicator**8. Number of SMI adults using services**

Value:	<u>73,195</u>	<u>73,927</u>	<u>74,666</u>	<u>75,413</u>
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POPULATION ACCESS INDICATOR

Goal 9:	Ensure that ethnic minorities have access to mental health services.
Objective:	Increase the number of ethnic minorities who use mental health services.
Population:	Adults with serious mental illness.
Criterion:	<i>Estimates of Prevalence and Treated Prevalence</i>
Brief Name:	Minorities served.
Indicator:	Number of minorities who are receiving community based mental health services.
Measure:	Comparison of number of people served over a three-year period.
Sources of Information:	DMHS Unified Services Transaction Form
Special Issues:	New Jersey's ethnic minority population, specifically, Hispanics, African Americans and Asians have increased steadily and significantly.
Significance:	As the state's ethnic minority population increases, the mental health system must concurrently meet the challenges of providing a corresponding increase in mental health services.

SFY '04	FY '05	FY '06	FY '07
<u>Baseline</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>

Population Access Indicator**9. Number of minorities receiving services**

Value:	<u>119,934</u>	<u>126,375</u>	<u>132,693</u>	<u>139,327</u>
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*FY 03 data as displayed in Table 2A & 2B.

CRITERION 3

CHILDREN'S SERVICES

Please refer to Children's Services Section of Plan

CRITERION 4***Targeted Services to Homeless and Rural Populations***

Mental health services, including outreach, will be provided to SMI and SED individuals who are homeless, and services will be provided to individuals residing in rural areas.

DESCRIPTIONServices to Homeless

The State of New Jersey has initiated a series of programs which involve the provision of permanent supportive housing in the community for individuals with special needs who are currently institutionalized, living in substandard boarding and rooming houses, homeless or at-risk of homelessness. One approach coordinates multiple funding sources for housing development, operations and service delivery. Since 1999, over \$10 million dollars has been provided to 43 provider agencies in all 21 counties to serve approximately 1600 individuals in Supportive Housing.

The New Jersey PATH program currently provides outreach, case management and support to nearly 2,000 individuals who have mental illness in all 21 counties. The Division currently receives Federal PATH funding of \$1,416,960 and provides a state match of \$2,408,671.

In Fiscal Year 2003, twenty-four PATH programs were funded. There were 5,937 outreach contacts with 1,867 consumers agreeing to accept services. 1038 were linked to mental health services, 1,276 to financial services, 566 to temporary housing/shelter, and 560 to long term housing.

The New Jersey State Policy Academy Team was developed in response to the national perspective on ending homelessness and the Federal requirement for states to develop ten year plans. The Governor's Office convened the Team as one of 10 states invited to attend the fourth Policy Academy forum held in Chicago, in May 2003 sponsored by Department of Health and Human Services, Housing and Urban Development and the Veterans Administration. The Team consisted of 13 housing representatives from the Governor's Office and three homeless provider agencies. The New Jersey Team worked with federal consultants to identify state strengths, weaknesses, opportunities and challenges. They developed a vision statement and identified priority areas to address in the State's Plan which was submitted for federal review and approved in 2004. The Plan identified the following priority areas:

- Improved data collection and coordination to identify needs and gaps in services.
- Improve system-wide coordination at all levels of systems delivery for homeless individuals and families in New Jersey.
- Increase opportunities that lead to permanent housing for homeless populations.
- Increase knowledge, linkage and utilization of mainstream services

- Reduce reliance on hotels/motels as long term housing for people who are homeless.

DMHS will continue to provide staff support for the Team's priorities as the plan is implemented.

Services to Rural Populations

The Division of Mental Health Services defines a county as "rural" if, according to U.S. Census figures, 25 percent or more of its population lived in rural areas. Six of New Jersey's twenty-one counties are defined as rural including: Sussex, Warren, Hunterdon (north/central); and Cumberland, Salem and Cape May (south). A full array of mental health services is available in all counties as part of the State's comprehensive system of mental health services. System Review Committees are established in each county and monitor the adequacy of the acute care system. Designated Screening Centers, Integrated Case Management, PACT, IFSS, Supported Employment and residential programs also operate in each county.

Community based services for rural populations were enhanced and expanded as part of the first Redirection Plan and through increases in Block Grant funding. Block Grant allocations were used to develop Traumatic Loss Coalitions (TLC) in all rural counties, to coordinate response services with schools in the event of a traumatic event affecting the school and its community. The TLC's are comprised of mental health professionals and representatives from schools, law enforcement, and social service agencies.

Training specific to the issues affecting rural counties has been provided to enhance mental health response capability to disasters or community incidents. Expanded efforts to provide technical assistance to these counties are being provided through federal grants. Technical assistance will assist County Mental Health Administrators to incorporate in their planning the issues in their counties that make them vulnerable to man made, technological or environmental disasters.

Allocations from DMHS to County Mental Health Boards are used to fund public education and training initiatives. The counties have used the allocations to fund informational materials, public education and other activities that address stigma. For example, one county continues to provide a full time mental health worker out-posted to the County Board of Social Services Office to educate social workers about mental illness and to trouble shoot and advocate for consumers.

SPECIAL POPULATION INDICATOR

Goal 10: **Ensure access to services for persons who are homeless and have a serious mental illness.**

Objective: Maintain capacity to provide outreach and linkage services to persons with serious mental illness who are homeless.

Population: Adults with serious mental illness.

Criterion: *Targeted Services to Homeless and Rural Populations*

Brief Name: Services to homeless populations.

Indicator: Number of homeless with SMI provided outreach services and offered access to mental health services.

Measure: Data on number who are SMI and homeless who are provided outreach services by mental health services staff.

Sources of Information: Quarterly contract monitoring report

Special Issues: The State of New Jersey continually seeks opportunities to increase the availability of permanent housing in the community for individuals with serious mental illnesses who are homeless or at-risk of homelessness. These efforts include coordination of multiple funding sources for housing development, operations and service delivery, and allocation of funds to provider agencies to increase supportive housing services as well as rental subsidies. In addition, 24 New Jersey PATH programs in 21 counties provide outreach case management to over 5,000 people, and ongoing support to more than 2,000 homeless individuals who have mental illness. In addition the coordinated efforts of the Policy Academy Team activities are expected to reduce the number of homeless persons over time.

Significance: New Jersey is challenged by the need to ensure affordable housing for its mental health consumers. Consumer satisfaction surveys consistently identify both housing and employment as key factors that contribute to quality of life and successful community integration.

SFY '04	FY '05	FY '06	FY '07
<u>Baseline</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>

Special Population Indicator**10. Number of homeless people served.**

Value:	<u>5937</u>	<u>5937</u>	<u>5937</u>	<u>5937</u>
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SPECIAL POPULATION INDICATOR

Goal 11: **Improve access to innovative services for persons with serious mental illness who live in rural counties.**

Objective: Increase number of persons receiving PACT services in rural counties.

Population: Adults with serious mental illness.

Criterion: *Targeted Services to Homeless and Rural Populations*

Brief Name: PACT services in rural counties.

Indicator: Number of persons receiving PACT services in rural counties.

Measure: Comparison of number of rural PACT service recipients over a three-year period.

Sources of Information: PACT Report

Special Issues: Innovative community based services for rural populations were enhanced and expanded as part of the first Redirection Plan. Additional funding was included in the FY 1998 budget to fund an additional PACT team to serve two rural counties. As part of Redirection II, PACT services were also expanded to the two remaining rural counties (Sussex and Salem).

Significance: PACT services will help consumers in rural counties to remain in the community and prevent unnecessary hospitalizations.

SFY '04	FY '05	FY '06	FY '07
<u>Baseline</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>

Special Population Indicator**11. Number receiving PACT in rural counties**

Value:	<u>186</u>	<u>231</u>	<u>276</u>	<u>311</u>
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CRITERION 5***Management System***

Financial and staffing resources, including human resource development of community mental health providers, will be available to implement the plan, and, the manner in which the state intends to expend the grant for the fiscal year will be described.

Staffing Resources and Training

In FY 2004 there were approximately 6,363 state and county full time hospital employees, and about 6,500 community mental health workers in agencies funded in part, or in full, by the Division of Mental Health Services. Although the Redirection II Plan is intended to expand community services to allow a redirection in state hospital census, there are no planned employee layoffs as a result of the initiative. The intent is to thereby increase the staff-to-patient ratio and improve the quality of services provided.

Through the first Redirection Plan in 1999, the DMHS was able to expand the number of Advance Practice Nurses (APNs) to supplement community mental health services. APNs are independent practitioners with prescriptive authority. They are now active in 21 contract agencies in New Jersey and their unique focus on holistic health issues and their valuable clinical skills have been well received by consumers as well as staff. To date, APNs have been working in adult outpatient, partial care, case management and screening programs. Due to the high demand for APNs in the community mental health system, DMHS again expanded this initiative in 2001 and still again in FY 2004 through the Redirection II Plan. A total of 45 APN positions are now supported throughout the state.

DMHS continues to fund the Technical Assistance Center (TAC) through University Behavioral Health Care (UBHC), out of the University of Medicine and Dentistry of New Jersey. Staff and consultants from the TAC provide technical assistance training to community providers in priority areas identified by DMHS. Some examples of projects include training in crisis management, emergency response, services to nursing home residents with psychiatric disorders, multicultural concerns and the clinical needs of persons who suffer from both a mental illness and chemical abuse (MICA). Expanded in FY 2004 through the Redirection II Plan, the TAC is also involved in Tobacco Cessation training, wellness and recovery programs, and Illness Management and Recovery training. Via the TAC contract, the DMHS continues to prioritize the certification and re-certification of emergency services screening workers each year as part of the Screening Law implementation. A statewide screening coordinators' meeting is held annually to discuss issues related to implementation of the screening law.

The PACT Training and Technical Assistance (TTA) initiative which is provided by an existing provider, Bridgeway House, provides two-day intensive training sessions including both didactic and in-vivo practicum for all new hires on a quarterly and regional (North/Central and South/Central) basis. Trainees are assigned a mentor who provides follow-up information and support. Specialty workshops are held for each of the professional disciplines on the teams and technical assistance has been focused on specific teams over a longer period of time around team development and fidelity to the PACT model.

The Division has also consistently prioritized efforts to provide mental health services within a culturally sensitive framework. A full time staff position with assistance from other central office staff as well as staff from the state psychiatric hospitals, provide support to various projects dedicated to multi-cultural concerns. The Division's Office of Multicultural Services meets regularly with a statewide Multicultural Services Advisory Committee comprised of mental health service providers, consumers, and members of the academic community to focus on ways to improve the quality of services delivered to consumers with linguistic and cultural needs. For the past nine years the Division has provided and will continue to offer, grants to foster linkages between community mental health agencies and other community agencies who serve minorities, and to improve access to mental health services for minorities. There continues to be an emphasis on assessing and addressing the cultural competence and training needs of the mental health work force. In this regard, the Division is developing strategies to train community mental health providers on how to improve the provision of culturally competent mental health services. A series of workshops are provided statewide designed to enable providers to practice implementing various techniques designed from the workshops. In addition, the provision of culturally appropriate services was a major component of the services provided in response to the World Trade Center Disaster.

During the past fourteen years mental health disaster planning and response has been an increasing focus for the Division of Mental Health Services. Training of both public and private mental health responders has been a critical component of mental health disaster preparedness both prior to and in the aftermath of the World Trade Center Disaster. Through funding from several grants in response to the disaster, the cadre of mental health counselors on the DMHS call up roster grew from 600 to approximately 1900 people. Training opportunities will continue to be provided and is being expanded to other professions such as teachers, nurses and faith based organizations.

The philosophy of the training per the requirements of the Center for Mental Health Services, is that most people affected by incidents or disasters are not and do not become seriously mentally ill, and are not the usual target population the Division serves. They are normal people having a normal reaction to an abnormal event. Mental health consumers may be affected and are considered a special population under the crisis counseling program, as are older adults and multicultural populations. Mental health providers are assisted through training to make this change in the manner in which they intervene with people affected by disaster. By providing a forum for people to tell their stories, validating their feelings and providing educational materials and referral sources, they can be assisted to return to a pre-disaster level of functioning. If people develop more serious problems they are referred to existing mental health services as appropriate. Another major premise of the program is that the ability to respond quickly when an event occurs may assist in the prevention of long term mental health problems.

Financial Resources and Description of Block Grant Services for Fiscal Year 2004

New Jersey has significantly increased funding for community mental health services in the past six years resulting in the closure of one state psychiatric hospital, initiation of plans to substantially reduce and reconfigure another state psychiatric hospital, as well as implementation of a wide range of new and enhanced community treatment and support programs. For example, in fiscal year 1998 state funding for Division of Mental Health Services community mental health programs totaled \$192,080,000 and has increased to an anticipated level of \$291.123 million for the current fiscal year (2005). This includes an additional \$30.1 million for the Division's "Redirection II" Plan and \$10.4 million to fund a \$1.00 per hour raise for all direct case service workers funded via community services contracts. Total funding from all sources for fiscal year 2005 community mental health services is projected to be \$309.066 million. Within this amount, the estimated total for adult community mental health services is \$253.730 million.

Goals

The goals that are promoted by the community mental health agencies funded under the Block Grant for adults include: ensuring access to traditional and non-traditional community based services for persons with serious mental illness; promoting the provision of services in the least restrictive setting and reducing the need for state psychiatric hospital admissions; achieving desired outcomes from community-based services for persons with serious mental illness; assessing utilization of mental health services by persons with serious mental illness; ensuring funds for community mental health programs are appropriately allocated and used to promote community based services; promoting a well-trained mental health workforce; ensuring access to services for persons who are homeless and have a serious mental illness; and ensuring access to services (including non-traditional services) for persons who live in rural counties of the state.

The goals that are promoted for children include access to mental health services; promoting interagency cooperation; continuing the development of a comprehensive, culturally competent, individualized, community-based, family focused, system of care for children and adolescents with serious emotional disturbances; and the development of outcome measures to assess the effectiveness of services. See Children's section for additional information.

While New Jersey currently has contracts with over 120 agencies who provide eligible Block Grant services, since the inception of the Block Grant, New Jersey allocated Block Grant funding primarily to the same group of approximately 35-40 agencies who had received pre-Block Grant Federal funding directly. This group of agencies and the amounts allocated to each, has been revised slightly over the years to reflect changes in Block Grant requirements, funding and service levels, and changes in the agencies' service programs due to mergers, name changes, etc. With the passage of P.L. 102-321 and its requirement for linking the expenditure of CMHS Block Grant funds to the State Plan, as well as the requirement to expend such funds only for services to adults with SMI and children with SED, the Division revised the manner in which funds were allocated among the aforementioned group of agencies. In order to ensure that funds are allocated and expended only for such services, a review of each of the agencies' contracts is conducted. The amount of services applicable to adults with SMI and children with SED is then calculated based on service demographics for each agency. The result of this calculation yields a total

pool of eligible costs, still for the 35-40 agencies, which is in excess of \$60.0 million. Consequently, the limited Block Grant funding is then allocated to each of the agencies based on the relative percentage of their eligible costs, to the total eligible costs of all agencies in the group.

With the receipt of the increased funding included in the federal fiscal year 2000 CMHS Block Grant Awards, DMHS conducted an extensive and deliberative process to identify potential initiatives to expand or implement new Block Grant eligible services, as well as consider supporting requests for one-time needs to bolster existing Block Grant eligible programs. After careful deliberation, the Division decided to fund the following four expansion initiatives with the increased fiscal year 2000 funding - Traumatic Loss Mental Health Interventions for Youth, Employment Resource Institutes, Intensive Family Support Services and Consumer-Operated Support Services. With the additional increased funding received via the federal fiscal year 2001 award, following the same careful, deliberative process, DMHS funded initiatives which further augmented and expanded family Support Services, Consumer-Operated Services, and Self-Help Centers. Additional initiatives include Service Support for Rental Subsidy Clients, Public Information and Outreach, Expansion of Advanced Nurses, a "Challenge Grant" related to consumers involved with the Criminal Justice System, and expanding support to the Planning Council.

The following pages reflect a breakdown of anticipated Block Grant expenditures by agency, for state fiscal years 2005 – 2007.

STATE OF NEW JERSEY - DIVISION OF MENTAL HEALTH SERVICES
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT
STATE FISCAL YEAR 2005 (7/1/04 - 6/30/05)

8/16/2004

[illegible]

SPECIAL POPULATION INDICATOR

Goal 12: Ensure funds for community mental health programs are appropriately allocated and used to promote community based services.

Objective: Maintain expenditures for community mental health programs.

Population: Adults with serious mental illness.

Criterion: *Management Systems*

Brief Name: Community expenditures.

Indicator: Maintain Division expenditures for community programs.

Measure: Total Division expenditures for community mental health programs.

Sources of Information: Division financial records.

Special Issues: New Jersey has significantly increased and enhanced community services over the past several years and continues to do so as a result of its major statewide Redirection initiative, as well as increased Block Grant and PATH Grant awards and a statewide Department of Human Services – Children Services Initiative.

Significance: Funding for community programs is essential to maintaining people in the community. Enhancements are planned or in process for self-help centers, PATH services, youth case management services, community residential settings, supportive housing, medication-related services and admission diversion services.

SFY '04	FY '05	FY '06	FY '07
<u>Baseline</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>

Special Population Indicator**12. Expenditures for community programs**

Value:	<u>\$281.008M</u>	<u>\$309.066M</u>	<u>\$309.066M</u>	<u>\$309.066M</u>
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ACCESS INDICATOR

Goal 13: **Promote a well-trained mental health workforce in anticipation of declared disasters or other traumatic events.**

Objective: Continue to provide training opportunities for the community mental health first responders.

Population: Mental Health Workforce

Criterion: *Management Systems*

Brief Name: Disaster Mental Health training.

Indicator: Maintain cadre of mental health providers trained to provide crisis counseling services.

Measure: Number of people trained.

Sources of Information: DMHS data base.

Special Issues: Providers will be offered a wide range of training opportunities to help prepare them for disaster response including information on bio-terror events, basic crisis counseling and information on the how mental health fits into the incident command system.

Significance: The ongoing threat of terrorism underscores the need to maintain a roster of people who are trained to respond to the needs of people affected by disaster.

SFY '04	FY '05	FY '06	FY '07
<u>Baseline</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>

Access Indicator**13. Number trained.**

Values:	<u>1900</u>	<u>2200</u>	<u>2500</u>	<u>2800</u>
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**PERSONS WHO ARE EMPLOYED, LIVE INDEPENDENTLY AND HAVE
CONTACT WITH THE CRIMINAL JUSTICE SYSTEM**

To assist the Center for Mental Health Services in meeting its own accountability requirements related to the Government Reporting Results Act, States were requested to report on the performance indicators listed below in this document.

Data from the Division of Mental Health Services Unified Services Transaction Forms (USTF) information system indicates that in fiscal year 2003, of adults admitted for services who were age 18 years of age or older, and who had a global level of functioning less than or equal to 5:

15.1% were employed
63.3% were living independently
13.1% had contact with the criminal justice system

PART TWO -- FFY 2005 - 2007 NEW JERSEY CHILDREN'S MENTAL HEALTH PLAN

SECTION I. DESCRIPTION OF STATE SERVICE SYSTEM

PROFILE OF THE STATE

Please see this section of the adult plan for general statewide demographic and economic information. Details of the increasing youth and minority populations, patterns of population shift, and risk factors for youth are detailed in Criterion 2 of the Children's Plan.

OVERVIEW OF THE CHILDREN'S MENTAL HEALTH SYSTEM

New Jersey's youth behavioral health service system is in transition. System change began with the closure of children's units in our adult state hospitals in 1978 and gained momentum in 1990 with the creation of the Youth Incentive Program (YIP) and the elimination of state operated inpatient beds for youth under the age of 11. Based upon CASSP principles, YIP stressed community-based, family-centered services and a decreasing reliance on inpatient care and out of home placement. YIP set the stage for true local service planning and case management. Progress toward a better system has now accelerated dramatically as the implementation of the Child Behavioral Health Services System (formerly known as the System of Care Initiative and the Partnership for Children) comes within sight of completion. This is occurring at a time when New Jersey has also begun a dramatic reworking of its Child Welfare System.

New Jersey is moving to complete the reform of children's services by integrating existing traditional services and adding innovative new components to the statewide system of care. The roles of traditional services and service providers are shifting and opportunities to provide dynamic in-community services are expanding. As the Child Behavioral Health Services System unfolds, families now have access to additional services, and they play the key role in selecting those services. During this time of change one constant goal remains central—to maintain and extend the availability of quality care to New Jersey's youth and their families.

Legislation has recently been enacted creating the Office of Children's Services within the Department of Human Services. This Office will act as a single umbrella over the three Divisions most concerned with children's welfare: the Division of Youth and Family Services, the Division of Child Behavioral Health Services, and the Division of Prevention and Community Partnership. An Office of Training was also created as a vital component of the Office of Children's Services.

The mission of these new Divisions is explained in the **New Developments/Issues** section.

A SYSTEM IN TRANSITION

As New Jersey evolves a better system of care for youth and families, elements of the traditional system are being integrated with new services as these are implemented. In some counties all of the new services are complete, while in others traditional services still provide much of the essential services.

Some counties, for example, still use volunteer Case Assessment Resource Teams (CART) to assist in the development of Individual Service Plans and to manage wraparound funds. As the Child Behavioral Health Services System is completed, the CARTs are being phased out and replaced with a newer, more responsive and accountable system.

For clarity, elements of the existing system and new services are described separately in the following two sections. It should be noted, however, that in all counties as DCBHS development progresses, these services exist side-by-side as system partners.

EXISTING TRADITIONAL CHILDREN'S MENTAL HEALTH SERVICES

Traditional services in New Jersey's service system consist of statewide, regional, sub-regional, and county based services.

New Jersey has provided inpatient treatment for youth under the age of 11 in non state operated community hospitals since 1990. The state's single remaining state operated psychiatric hospital, the 40 bed Arthur Brisbane Child Treatment Center, currently serves adolescents age 11 through 17 who require continued hospitalization following acute inpatient treatment in a community based crisis unit. This state facility also provides acute inpatient services to adjudicated youth who are incarcerated in Juvenile Justice Commission facilities and to youth with serious charges who are awaiting adjudication in county youth detention centers. Planning is underway to phase down this facility and provide these services closer to home in alternative treatment settings. The unit is scheduled to close during SFY 2006.

Elements of the traditional service system that are an important part of New Jersey's service continuum include:

Children and youth experiencing a psychiatric crisis access inpatient hospitalization through **Screening /Emergency Services** which are available 24 hours a day, seven days a week typically within community hospitals' emergency service departments. **Children's Crisis Intervention Services**, located in community hospitals, are acute inpatient units which provide screening, stabilization, assessment and short-term intensive treatment. These units are licensed by the Department of Health and Senior Services following designation by the Division of Child Behavioral Health Services.

Long-term hospital care for committed 11-17 year old youth is provided at the 40 bed **Arthur Brisbane Child Treatment Center**, the only state psychiatric hospital for youth. As mentioned elsewhere, this facility will be replaced with alternative services that will be more accessible to youth and their families.

Youth under the age of 11 needing long-term treatment are referred to **Psychiatric Community Residences for 5-10 year olds**. These specialized group homes

provide intensive psychiatric services and are the alternative to state psychiatric hospitalization for this age group. Each residence serves up to 8 children for an average length of stay of six months. **Psychiatric Community Residence Programs for 11-17 year olds** provide the same alternative for older children and adolescents who are hospitalized in Children's Crisis Intervention Service units and who need continued treatment within a structured residential setting following inpatient treatment.

When needed, longer term **Residential Treatment** is provided through the DCBHS or the Division of Youth and Family Services.

Aging-In Community Residences have been developed for youth who are transitioning from the children's mental health system and will continue to require support as young adults.

New Jersey children now have access to three levels of **Case Management**, a county based service designed to facilitate the coordination, continuity, accessibility and accountability of services. The expansion of case management services is detailed under Criterion 1.

Partial Care Programs are intensive, non-residential services generally provided in after-school or half day programs which can include counseling, psychiatric assessment, medication, behavior management, rehabilitation and recreation components.

Most youth access the mental health system through **Outpatient Services** which are available in a variety of community agencies and settings. Services include individual, group and family therapy, medication management, and therapeutic recreation.

School-Based Youth Services programs, expanded in this year's budget to 45 school districts, offer a range of services including individual and family counseling, drug and alcohol abuse counseling, employment counseling, training and job placement, summer and part-time job development, referrals to health and social services, and opportunities for recreation. Sites may also offer daycare, teen parenting instruction, special vocational programs, transportation and hot lines.

In some counties where new DCBHS services are being developed youth at all levels of service may also receive services through existing county-based, individualized service planning teams known as **Case Assessment Resource Teams (CART)**. CART child/family teams use a wraparound planning process and flexible funds to develop community based plans as alternatives to or as transitions from residential placement or state psychiatric hospitalization back to the community. In addition to the services described above, the CARTs provide access to therapeutic foster care, behavioral assistance and in-home counseling and support. As DCBHS services are fully developed in all New Jersey counties the CART system is being phased out.

TRADITIONAL SERVICE UTILIZATION

Most recent service utilization numbers for all youth served in the public mental health system include:

<u>Program Element</u>	<u>Episodes</u>
Emergency/Screening	8,255 (SFY '03)
Inpatient CCIS	4,502 (SFY '04)
Inpatient ABCTC	92 (SFY '04)
Psychiatric Community Residence	383 (SFY '03)
Partial Care	2,954 (SFY '03)
Outpatient	31,698 (SFY '03)

The Division of Mental Health Services' Unified Services Client Registry information system (USTF) indicates that youth accounted for a minimum of 15.2% of all episodes of care provided by publicly funded mental health services. Other services are known to benefit children and youth, but may not be recorded in a manner that separates data (such as when family counseling includes youth).

NEW CHILDREN'S MENTAL HEALTH SERVICES

New Jersey has **Expanded Case Management** and now provides three tiers of this service to address the varied needs of children and families. **Care Coordination** is provided by the Contracted Systems Administrator for children and families who are able to access and utilize services with minimal support. This level of service is available by telephone only. **Youth Case Management** is provided by Youth Case Management Programs for children and families who require moderate, face-to-face guidance and support to access and utilize services appropriately. DCBHS has increased the number of full time youth case managers from 74 to 160 statewide. The additional youth case managers were allocated to existing youth case management programs in each county by population and service use patterns. **Intensive Care Management** is provided by Care Management Organizations (CMO) for children and families whose needs are the most complex, who have multi-systemic involvement, and who require substantial assistance to access and utilize services appropriately. CMOs now exist in ten service areas covering eleven counties. Five more CMOs are planned for implementation during this block grant plan cycle.

Family Support Organizations (FSO) are family-run, county-based organizations that provide direct family-to-family peer support, education, advocacy and other services to family members of children with emotional and behavioral problems. Ten FSOs, developed concurrently with CMOs, are now operational in the ten existing CMO service areas.

Mobile Response and Stabilization Services (MRSS) is a single, integrated, comprehensive system of mobile response, stabilization intervention and transition to community supports. This system is available to children and youth whose escalating emotional or behavioral issues require timely interventions to prevent disruption of their current living arrangement, including out-of-home placement. MRSS is a face-to-face delivery of service at the site of the escalating behavior, whether this is the child's home, a group home or another living arrangement, including resource and foster family homes. Mobile Response Services are

focused, time limited, intensive, preventive and include behavioral and rehabilitative interventions designed specifically to diffuse, mitigate and resolve a crisis. Because of its demonstrated success the service has been expanded in advance of other new DCBHS services. It is now available in 16 counties with plans to expand into the remaining five counties during this plan cycle.

Intensive In-Community Services are flexible, multi-purpose, in-home/community clinical services and supports for parents/caregivers and children with behavioral and emotional disturbances. The purpose of these services is to strengthen the family, to provide family stability and to preserve the family constellation in the community setting. Services are flexible as to where and when they are provided based on the family's needs. Interventions may be provided as a component of Mobile Response and Stabilization or as a longer-term treatment intervention. This family-driven treatment is based on targeted needs as identified in the Individual Service Plan (ISP). The ISP also includes specific interventions with target dates for accomplishment of goals that focus on the restorative functioning of the child/youth and family. This new service is available statewide.

Also delivered as part of an Individualized Services Plan, **Behavioral Assistance** provides specific, outcome-oriented interventions that are components of a detailed plan of care prepared by a licensed clinical behavioral healthcare practitioner. Behavioral Assistance is a dynamic process of intervention and ongoing evaluation resulting in effective modification of specific identified behaviors. Behavioral Assistance services involve applying positive behavioral principles within the community using culturally based norms to foster behaviors that are rehabilitative and restorative in nature. The model is flexible, allowing for some interventions to be provided in a group setting. Behavioral Assistance has been added statewide.

Alternative Crisis Treatment Beds provide a short-term stabilization response that provides intensive treatment in a licensed, highly structured residential program for children/youth for up to seven days. Crisis treatment beds provide an opportunity for stabilization. The respite enables the family to work intensely with the Mobile Response Team so they will be ready to take the child/youth back within seven days. This intervention provides a safe, controlled environment with a high degree of supervision and structure in which the child receives therapeutic intervention and specialized programming designed to stabilize the child within seven days in preparation for reintegration into the living environment from which he/she came. This service is available in two counties and will be expanded during this plan cycle.

Emergency Treatment Home Beds provide the same service for youth who are able to receive stabilization services in a less structured treatment home setting. The Mobile Response Stabilization Team coordinates these levels of care.

NEW SERVICE UTILIZATION

The Division of Child Behavioral Health Services serves youth from all 21 counties. In addition to existing traditional mental health services, as of August 2004, new DCBHS service provision to youth is as follows:

Total Number Served	17,892
Current Active in CMO	1,436
Current Active in YCM	1,477
Total Served by MRSS	4,181
Total Families supported by FSO	612

SECTION II: SUMMARY OF ACHIEVEMENTS/AREAS OF CONTINUING IMPROVEMENT

NEW DEVELOPMENTS/ISSUES

The new mission of the Division of Youth and Family Services will include focusing on outcomes for children rather than process for workers, separating the task of investigating allegations of abuse from the task of ongoing service and support to families and children, increasing the numbers of workers and decreasing caseloads, and, providing caseworkers and families with access to adequate and appropriate services and resources in families' own neighborhoods.

The Division of Mental Health Services' (DMHS) central office staff and regional children's services coordinators have become part of the new Division of Child Behavioral Health Services. The Division of Child Behavioral Health Services was created in the Department of Human Services to coordinate and expand existing services and to develop new community services to help youth and their families recognize their strengths and plan services to meet their needs. DCBHS views children and their families as full partners in the development of their Individual Service Plans and in assessing progress toward their own outcomes. When the service plan necessitates an out of home placement, children are matched with the right placement for the level of care they need, with treatment services that maximize the likelihood that they will be able to return home or, if that is not possible, to a resource family in the community. The Division of Child Behavioral Health Services is comprised of the Office of Policy, Planning and Quality Assurance, and the Office of Operations. DCBHS provides leadership in the coordination of the development of services and, through its Contracted Systems Administrator, provides coordination of services for individual youth and families by providing case management at the level needed by each family.

The Division of Prevention and Community Partnership will help identify and support an integrated network of services for children and families in partnership with the communities in which they live. These services will include domestic violence services, substance abuse, children's behavioral health, health and medical services and housing. Services will be targeted to children and families currently involved with DYFS and, for the first time, those at risk of DYFS involvement.

OVERVIEW OF THE REFORM OF CHILD BEHAVIORAL HEALTH SERVICES

New Jersey has committed to a major structural reform of the current children's service system that will significantly change the financing, contracting, organization, and delivery of services for children and their families. The goal of the Division of Child Behavioral Health Services is a comprehensive system of care based on the fundamental principle that children and adolescents have the greatest opportunity for normal, healthy development when ties to community and family are maintained. New Jersey has designed a reform agenda committed to maintaining the integrity of family and community life for children while delivering effective clinical care and social support services.

The Child Behavioral Health Services System is a multi-year initiative that has significantly increased spending in combined state and federal funding to broaden the range of community-based treatment and to accomplish a reworking of how children's services are funded and coordinated in New Jersey. In state fiscal year 2004, combined state and federal funding and Medicaid plan amendments were

used for continued service expansion and the development of the Child Behavioral Health Services System. Despite budget deficits in each of the last three years, the reform agenda has continued and state funding has been expanded.

The Child Behavioral Health Services System serves all children with emotional and behavioral disturbances and their families who enter publicly funded systems, including child welfare, mental health and juvenile justice, from ages 0-18, as well as youth 18-21 who are transitioning to the adult system. The Child Behavioral Health Services System pools resources from Child Welfare, Mental Health and Medicaid, investing in new resources and managing those resources so that services are expanded and tailored to meet the needs of each individual child and family. Establishing a system to register and track children and services has enabled the state to coordinate service development, monitor service delivery and costs for children with multiple needs and their families.

As the statewide initiative unfolds, the Statewide Implementation Advisory Committee continues to play an important role. This 40-person advisory group meets monthly to provide input on the implementation and to assist the Division of Child Behavioral Health Services in developing strategies to ensure the reform goals will be met. In addition to family members, the committee includes representation from providers, advocates, clergy and related government agencies: the Department of Human Services, the Division of Youth and Family Services, Division of Child Behavioral Health Services, Medicaid, Juvenile Justice Commission, Administrative Office of the Courts, Division of Addiction Services, and the Department of Education. This group is ever mindful of the main goal of the Child Behavioral Health System—to provide children and families quick access to a broad array of services and resources, to provide choice in service selection, and to invite families to participate in the development of their child's service plan to meet the unique needs of each child and family.

MAJOR COMPONENTS OF THE CHILD BEHAVIORAL HEALTH SERVICES SYSTEM

- A Statewide Contracted System Administrator (CSA) to support utilization management, care coordination, quality management, and information management for the statewide system of care. The CSA provides the Department of Human Services, the CMOs and other system partners with the information needed to manage the Individual Service Planning process toward child and family satisfaction, quality outcomes and cost effectiveness.
- Care Management Organizations (CMOs) to organize and coordinate community-based services and informal resources through face-to-face care management at the local level for individual children and families with multi-service needs and multi-system involvement. These new non-profit organizations provide a full range of treatment and support services to children with the most complex needs. They work with child-family teams to develop individualized service plans. The CMOs' goals are to keep children in their homes, their schools and their communities.
- Family Support Organizations (FSOs) to provide direct peer support and assistance to children and families by family members of children with current system involvement. FSOs are developed concurrently with CMOs.

STATUS OF CHILD BEHAVIORAL HEALTH SERVICES SYSTEM DEVELOPMENT

The **Contracted Systems Administrator (CSA)** is fully operational and is continually building and refining its capacity to provide comprehensive data to the Department of Human Services. The CSA creates a virtual single point of processing that registers all enrollees, authorizes services, tracks and coordinates care for all New Jersey children who are screened into the system at any level. The CSA acts as an agent of state government contracted by and accountable to the Department of Human Services to manage services. The CSA is not risk based and has no incentive to restrict care.

Ten **Care Management Organizations (CMO)** are now providing care coordination for youth and families with complex needs from Atlantic/Cape May, Bergen, Burlington, Camden, Hudson, Essex, Mercer, Middlesex, Monmouth, and Union Counties. During phase-up, each CMO adds ten to twenty youth per month—over 1,400 youth have been enrolled in CMO services. The Camden and Essex CMOs were added this year, bringing this vital service to two of New Jersey's most urban and needy counties. Five more CMOs are scheduled to become operational during the course of this plan.

Paralleling the development of each CMO is the development of a **Family Support Organization (FSO)**, a parent run organization that provides assistance to families in CMO counties through peer mentorship, education and advocacy, information, referral, and the hosting of parent and peer support groups. FSOs act as a guide for professionals and provide direct peer support to families whose children are enrolled in DCBHS services.

Mobile Response and Stabilization Services are now in place in sixteen counties. This outreach service has demonstrated a 94% success rate in maintaining youth in their current placement and avoiding placement disruption. The Child Behavioral Health Services System has extended Mobile Response to additional counties in advance of CMO development.

Intensive In-Community Services and **Behavioral Assistance Services** are available statewide.

OTHER EVIDENCE BASED/BEST PRACTICES INITIATIVES AND ACTIVITIES

Treatment Homes are New Jersey's approach to Therapeutic Foster Care. This level of care is for children who require more intensive treatment and supervision than is found in a traditional or kinship foster care placement. Children are placed in the safe environment of a private home setting, licensed as a treatment home and the treating parents have received specialized training in the care of children with emotional and behavioral problems. Treatment Homes are designed for children with behavioral and functional disturbances who have the capability to engage in community-based activities in a family setting. Community resources are used in a planned, purposeful and therapeutic manner that encourages residents' autonomy appropriate to their level of functioning and safety and as indicated in their Individual Service Plan. Services provided in this setting may include mentoring, counseling, behavioral management and crisis intervention. Treatment parents participate as

part of the Child Family Team (if the child/youth is in the CMO) and assure that the youngster receives needed psychiatric and psychological services, medical care and education. Treatment parents receive supervision and are supported by the staff and programs of the treatment home agency. This level of care is transitional, typically considered for children who have been recently discharged or are being diverted from a more intensive level of care. It is intended to maintain the child in the community while preparing for permanency placement—return to family of origin, adoption, permanent foster care, kinship care or independent living.

Reduction of the use of Seclusion and Restraint in Inpatient Settings began in 1995 with a revised Children's Crisis Intervention Service (CCIS) annual designation process which monitored the use of seclusion and restraint. The use of these modalities has decreased dramatically statewide over the years to the point where several CCIS units are able to report no incidents of seclusion or restraint for up to six months at a time, and an annual usage of these interventions of less than four episodes per year.

A Specialized In-Home Aftercare Service has been piloted in Essex County. Youth hospitalized in a Children's Crisis Intervention Service (CCIS) from this urban county were noted to have a higher than expected incidence of physical health issues, most notably asthma and diabetes. In addition, readmissions to CCIS were often associated with a lack of adherence to medication administration and other treatment recommendations. To help families needing additional assistance with the management of physical and psychiatric medications and treatment services, an Advanced Practice Nurse with certification in child/adolescent mental health clinical practice was recruited. This APN meets families before a child is discharged from the hospital, then provides medication monitoring, medication education, guidance and support in the child's home setting until the family is able to manage on their own. The APN works with Case Management to ensure that the necessary range of services is in place to meet the needs of the child and family.

Through the Children's Crisis Intervention Service (CCIS) annual designation process, DCBHS has begun to address the **Quality of Communication** provided to families and aftercare providers when a child is discharged from an inpatient setting. This effort is aimed at improving the sharing of important clinical and behavioral information that will help families and aftercare providers manage the behaviors that led to hospitalization and that may reemerge after discharge. Inpatient treatment teams are being encouraged to make the communication of successful behavior management strategies a specific part of discharge planning.

Traumatic Loss Coalitions (TLC) were developed in each county during the last three year plan. This development was accelerated following the attack on the World Trade Center. Coalitions have set new goals and priorities that are detailed in Criterion 3.

Flexible Wraparound Funds for Non-Traditional Supports are available to children and families served by Mobile Response and Stabilization Services and by all levels of Case Management.

SECTION III: IDENTIFICATION AND ANALYSIS OF THE SERVICE SYSTEM'S STRENGTHS, NEEDS AND PRIORITIES

Strengths:

- The consolidation of youth services in the Department of Human Services under one Office of Children's Services.
- The initiation of New Jersey's Child Welfare Reform Plan which coincides with, and will be integrated with, the reworking of the Child Behavioral Health Services System.
- The inclusion of families in planning and implementing system change and the focus on the importance of family participation in treatment decisions.
- The development and implementation of a uniform assessment tool and assessment process.
- The inclusion of youth involved with juvenile justice in the system of care.
- The expansion of the capacity and the mission of youth case management.
- The creation of new pathways to services to increase access for underserved populations.
- The development of new services and the state's commitment to full implementation of system reform.

Challenges:

- The development of the Division of Child Behavioral Health Services, a new Division of State government, while also implementing dramatic statewide service system reform.
- The creation of solutions to fiscal management, contracting and licensing issues that arise as services merge across Division lines.
- The maintenance of quality care in both traditional and new services during a time of change.
- The development of new standards for quality improvement based upon outcome measurement.
- The provision of specialized statewide and local training and retraining on a host of topics.

ANALYSIS OF UNMET NEEDS AND CRITICAL GAPS IN THE CURRENT SYSTEM:

Care Management Organizations and their corresponding Family Support Organizations are still to be developed in five Service Areas.

Mobile Response and Stabilization Services are not yet operational in all counties.

Alternative services must be developed to ensure that alternative safe longer term care is available to replace that provided by the Arthur Brisbane Child Treatment Center when that facility closes. This includes provisions for the inpatient service needs of youth committed to the Juvenile Justice Commission who require secure care.

STATEMENT OF THE STATE'S PRIORITIES AND PLANS TO ADDRESS UNMET NEEDS:

New Jersey has demonstrated its strong commitment to meeting the needs of youth and their families by creating the Office of Children's Services within the Department of Human Services to coordinate the three Divisions most concerned with children's welfare: the Division of Youth and Family Services, the Division of Child Behavioral Health Services, and the Division of Prevention and Community Partnership.

New Jersey has committed to a major structural reform of the current children's service system that will significantly change the financing, contracting, organization, and delivery of services for children and their families. The Child Behavioral Health Services System (DCBHS) is driven by the vision of a comprehensive system of care based on the fundamental principle that children and adolescents have the greatest opportunity for normal, healthy development when ties to community and family are maintained. To bring this system into being New Jersey has initiated a reform agenda committed to maintaining the integrity of family and community life for children while delivering effective clinical care and social support services. The principles inherent in this new system of care require the system to adhere to a core set of values. These are that services must be:

- **Child-centered and strength-based**, addressing the whole child across life domains and building on child and family strengths in all service planning, organization, and delivery.
- **Family-focused and family-friendly**, with all processes designed to engage families and directly involve them with service planning and delivery, and to assure their needs and goals drive the Individual Service Planning (ISP) and implementation process.
- **Community-based and culturally competent**, organizing services around community strengths, in local neighborhoods, and assuring responsiveness to the unique cultures of families living in those communities.
- **Collaborative across child-serving systems**, involving mental health, child welfare, juvenile justice and other system partners in common language, planning, financing, and contracting processes.

The principal elements of the Children's Initiative include:

- building culturally competent, individualized service plans to meet the needs of the child and giving families a greater say in their child's treatment.
- expanding the array of services available to children in their own homes and communities;
- creating a comprehensive and accountable management system to manage and coordinate care across systems;

- increasing funding for services.

The new Child Behavioral Health Services System is expected to be fully in place statewide by the end of this three year plan. An ambitious implementation schedule was initially set for the restructuring of services. Although budget concerns delayed the full deployment of new services, steady progress has continued each year. The reform momentum was sustained as a direct result of the strong commitment of the Governor and State Legislature who responded to the need to improve services for children by providing money in lean budgets to ensure continual movement forward. The CBHS initiative covers all children with emotional and behavioral disturbances and their families who enter publicly funded systems, including child welfare, mental health and juvenile justice, from ages 0-18, as well as youth 18-21 who may be transitioning to the adult system. The CBHS has pooled resources from Child Welfare, Mental Health and Medicaid, investing in new resources and managing those resources so that services are expanded and tailored to meet the needs of each individual child and family. By establishing a uniform assessment tool and assessment process in addition to a system to register and track children, the state is increasingly able to ensure the provision of appropriate, coordinated services for children with multiple needs.

DESCRIPTION OF HOW THE STATE MENTAL HEALTH AGENCY PROVIDES LEADERSHIP ON COORDINATING MENTAL HEALTH SERVICES WITHIN THE BROADER SYSTEM

New Jersey's Department of Human Services had long envisioned an expanded system of children's services with a full array of individualized in-home and wraparound services as well as readily available outpatient services and local community based residential treatment programs. This family-focused system, designed to address client and family strengths and to involve and empower parents as vital contributors to their children's treatment, will provide support to parents when needed, and consistently integrate services across all child serving systems.

Under the leadership of the Department of Human Services, remarkable progress has been made toward the new system of care in the brief time since January 2000 when planning for what is now known as the Child Behavioral Health Services System began. When fully implemented, the Child Behavioral Health Services System will provide fully integrated services to youth and their families to a degree that had not been possible in the current system.

ROLE OF THE IMPLEMENTATION ADVISORY COMMITTEE

As the statewide service reform unfolds, the Child Behavioral Health Services System Implementation Advisory Committee has assumed the advisory role formerly filled by the Children's Coordinating Council. This 40-person advisory group meets monthly to provide input on policy development and implementation and to assist the Department of Human Services (DHS) in developing strategies to ensure the reform goals will be met. The Committee is chaired by the Deputy Commissioner of DHS and, in addition to seven family members, includes representation from providers, advocates, clergy and related government agencies: the Division of Youth and Family Services, Division of Child Behavioral Health

Services, Medicaid, Juvenile Justice Commission, Administrative Office of the Courts, Division of Addiction Services, and the Department of Education.

CONTRIBUTIONS OF THE CHILDREN'S MENTAL HEALTH PLANNING COMMITTEE

The Children's Mental Health Planning Committee met throughout the year to develop indicators for the children's section of the plan. Representatives from mental health, juvenile justice, child welfare, education, and parents serve on the children's committee. The Chair of this workgroup is also a member of the Implementation Advisory Committee and the State Mental Health Board/Planning Advisory Council. The Child Behavioral Health Services System embodies dramatic changes in the way services are provided for youth and their families. The Planning Committee worked to develop indicators and measures that reflect the system's development as well as some of the anticipated positive outcomes of this system reform initiative.

The Children's Plan was distributed to the Mental Health Administrators in each county for review and input.

PLAN FORMAT

New Jersey has elected to submit a three year plan in the consolidated five criteria format. As in past years, New Jersey is submitting one plan with separate sections for adults and for children. Performance indicators have been developed for each of the five criteria, using the format suggested by the Center for Mental Health Services. The performance measures follow each Criterion.

A number of measures related to the Child Behavioral Health Services System have been included in New Jersey's 2002-2004 Block Grant Plan. Details of Child Behavioral Health Services System component development are presented in specific performance measures. In addition to system development measures, new measures based on MHSIP surveys of child and parent satisfaction have been incorporated in performance measures. Slight modifications and additions were made to the MHSIP to accommodate the unique needs of the Division of Child Behavioral Health Services. Our MHSIP surveys for youth and family/caregivers are included in Appendix A.

**SECTION IV: PERFORMANCE MEASURES AND PLANS TO
IMPROVE THE SERVICE SYSTEM**

CRITERION 1

Comprehensive Community-based Mental Health Service System

A comprehensive community-based system of mental health care for SMI adults and for youth with SED, including case management, rehabilitation, employment, housing, educational, medical, dental, and other support services, which enables individuals to function in the community and reduces the rate of hospitalization and residential placement will be developed and implemented.

Overview

With the closure of children's units in adult state hospitals, which began in the 1970's, New Jersey began the development of a comprehensive community-based system of mental health services that has continued to evolve to meet the needs of children, adolescents and their families. Since 1989, all mental health services for children under 12 years of age, including inpatient services, have been delivered in the community. One small 40-bed freestanding state hospital continues to serve adolescents who require additional inpatient treatment following crisis stabilization in community hospitals. This facility will be replaced by less institutional services and will be closed by the end of this plan cycle.

New community mental health services have been developed to meet the needs of New Jersey's youth and families closer to home, facilitating family participation and maintaining community ties. Through the 1990's innovative programs, such as the Youth Incentive Program with its child-family teams and wraparound capabilities, demonstrated the value of community-based, family focused services. Now, with the development of the Child Behavioral Health Services System, New Jersey's Department of Human Services continues its transition from a comprehensive mental health system to a comprehensive child-serving system, one that includes all child-serving system partners.

In New Jersey the Department of Human Services includes several Divisions which provide services to youth and families. Although youth with serious emotional disturbances may be involved with more than one agency or service system, the Division of Child Behavioral Health Services (DCBHS) has the primary state responsibility for mental health service provision to this target population. Assuming the function formerly housed with adult mental health services in the Division of Mental Health Services, DCBHS now coordinates the state mental health plan for children, allocates state and federal resources for mental health programs, promulgates standards for services, and operates the only state psychiatric facility for adolescents. The Division of Youth and Family Services also provides services to seriously emotionally disturbed children and adolescents through its legislative mandate for child protective services. As the child welfare agency, the Division of Youth And Family Services (DYFS) is responsible for child protection services and for effecting residential placements for New Jersey youth. When fully implemented, the Child Welfare Reform Plan will restructure DYFS and redesign case practice to

state-of-the-art standards. The Division of Developmental Disabilities shares responsibility with DCBHS for providing services for youth with developmental disabilities who also have serious emotional and behavioral disturbances.

New Jersey's Division of Child Behavioral Health Services provides, funds, or arranges for the following services for children and adolescents with serious emotional and behavioral disturbances and their families: diagnostic and evaluation services; inpatient services and alternatives to inpatient care; outpatient services; group and family counseling services; professional consultation; the review and management of medication; case management; screening/emergency services, 24 hours a day, 7 days a week, including mobile response and stabilization services; intensive in-community and home-based services, including behavioral assistance; intensive day treatment and partial care services; treatment homes; residential treatment; therapeutic group homes; respite care; and parent-run family support.

The Department of Human Services and each of its Divisions have established cooperative relationships with the Juvenile Justice Commission. The Juvenile Justice Commission is responsible for operating state services and sanctions for juveniles and for developing a statewide plan for the effective provision of juvenile justice services and sanctions at the state, county, and local levels. To emphasize New Jersey's commitment to provide coordinated quality services and appropriate sanctions for youthful offenders while ensuring the public's safety, the Juvenile Justice Commission established the State/Community Partnership Grant Program. These Partnership Grants provide funding to each county for services to reduce detention overcrowding, to provide treatment for sex offenders, to increase disposition options, and to provide aftercare to youth and their families.

During the three year period, 2005 through 2007, DCBHS will continue to work to increase coordination and to reform and improve its system of care for children and adolescents with serious emotional disturbances and their families, while increasing its ability to measure the effectiveness of its services. As a primary partner in the development of the Child Behavioral Health Services System, the Division of Child Behavioral Health Services will continue to work toward the Department's goals. These goals include statewide and regional efforts to improve the quality of services, to assure access, to provide strength-based services to special needs populations, to develop valid service outcome measures, to heighten the awareness of the need for culturally competent services, to continue to strengthen family support, advocacy and parent participation in all levels of policy development and planning, and to enhance data capabilities regarding youth behavioral health services.

Support Services

In New Jersey, the system of care facilitates the provision of ancillary services to the target populations through coordination, memoranda of understanding, and formal agreements with relevant state agencies and providers. Educational services are provided through the Department of Education and the Department of Human Service's Office of Education. Health and dental services are accessed through the Department of Health and Senior Services, as well as the Department of Human Services' Division of Medical Assistance and Health Services. Vocational counseling and rehabilitation are provided by the Division of Vocational Rehabilitation. The Division of Youth and Family Services provides permanency planning, protection and advocacy, child welfare, family support and preservation

services. Services for the developmentally disabled are provided by the Division of Developmental Disabilities.

The Department of Human Services' School-Based Youth Services programs are located on-site in 42 urban, suburban and rural school districts, with at least one site in each county. Each site offers a range of services including individual and family counseling, drug and alcohol abuse counseling, employment counseling, training and job placement, summer and part-time job development, referrals to health and social services, and opportunities for recreation. Sites may also offer daycare, teen parenting instruction, special vocational programs, transportation and hot lines.

Department of Human Services regulations stipulate that physical health and dental services must be provided or arranged for all residents of psychiatric community residences for children and for adolescents. Case managers assist families by coordinating medical and dental appointments for children and family members when necessary. Wraparound funding is available locally to purchase necessary services not available within the system of services to meet the unique needs of children and adolescents and their families.

Over the next three years, while completing the transition to full statewide implementation of the Child Behavioral Health Services System, New Jersey will maintain its established support services and will continue to provide unique or unavailable support services with wraparound funds until all such services are fully integrated within the new system.

New Jersey will continue to shift the focus of services toward community-based, family-focused and in-home supports and services. As Care Management Organizations (CMO) are added, they will assume the functions formerly provided by County Case Assessment Resource Teams (CART) by developing Individual Service Plans with families, securing, coordinating and monitoring services, progress and outcomes. The role of child/family teams, which first brought the delivery of services to a personal level for families, will continue to expand as CMO's are added. Efforts to limit the duration of out of home placements and to return children from long-term residential programs inside and outside of New Jersey to their home communities with flexible, individualized services will continue to be a priority for New Jersey's youth services.

Case Management

New Jersey has provided case management services for children and adolescents since 1987. The Division of Child Behavioral Health Services provides funding for twenty-one youth case management programs statewide. In all 21 counties, youth case management is a significant link in a child and family driven, community-based system of care. DCBHS case management services are off-site, community-based services for youth and their families intended to assist them in identifying, accessing and receiving appropriate services. Case management is designed for youth with SED who are at risk of hospitalization or out of home placement and who need an array of mental health and additional support services and service coordination. Case management is an important service which is initiated prior to a youth returning to a community setting from an out-of-home placement. Case management encompasses service assessment, service brokering, providing service linkages, advocacy, and case monitoring.

Division of Child Behavioral Health Services Case Managers are often involved in the transition process for youth with SED who are approaching adulthood and will need adult mental health and other support services. The Department of Human Services has established a process that contributes to better planning for the transition to adult services. This process coordinates case management and other youth services with adult Integrated Case Management Services (ICMS) in each county.

New Jersey provides three tiers of case management to address the varied needs of children and families:

- Care Coordination provided by the Contracted Systems Administrator for children and families who are able to access and utilize services with minimal support. This level of service is available by telephone only.
- Youth Case Management provided by Youth Case Management Programs for children and families who require moderate, face-to-face guidance and support to access and utilize services appropriately.
- Care Management provided by Care Management Organizations (CMO) for children and families who require substantial assistance to access and utilize services appropriately. The child/family team model is an intrinsic component of Care Management.

The Contracted Systems Administrator (CSA) determines the appropriate level of case management involvement for all children and families. If the CSA determines that a child requires the most intensive level of case management, referral to the CMO for Care Management is initiated. A child who needs a moderate level of case management will be referred to Youth Case Management for face-to-face community-based support services. If the CSA determines that the child requires services that a family can access on their own, the CSA will provide telephonic case management services.

Intensive Care Management Provided by a Care Management Organization

The Child Behavioral Health Services System, which is detailed under Criterion 3, is creating contracted Care Management Organizations (CMO) throughout New Jersey. The first CMOs began operation in January 2001 and others have been phased-in each year. Families with multiple system involvement and children with serious emotional and behavioral health needs in, or at imminent risk for, placement outside the home and community are candidates for community-based care management delivered by contracted CMOs. DHS screening and assessment criteria and standards are being used to identify eligible children and families for enrollment in a designated CMO.

In collaboration with each enrolled youth and family, the CMO designs and implements a single, integrated plan of care that incorporates interdisciplinary clinical services with family and community resources. The plan of care is implemented under the direction and authority of a child/family team, organized and facilitated by a CMO care manager. Care managers are individuals with extensive experience working with children with emotional and behavioral disturbances and their families who are involved with multiple child-serving systems. For these children with the most intensive needs the care manager to child ratio is 1:10. This is the ratio recommended by the federal Center for Mental Health Services. The

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child/ family team may include representatives from all involved child-serving systems, as well as key providers, family members, and community residents. All services are delivered and monitored under the authority of that team, and accountable to outcomes endorsed by the family.

The Division of Child Behavioral Health Services, through the Contracted Systems Administrator, monitors the plan of care implementation for quality and outcomes.

**NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION:
CRITERION 1—MEASURE A**

Goal: Reduce reliance on inpatient hospitalization.
Objective: Decrease inpatient readmissions.
Population: Youth with Serious Emotional or Behavioral Disturbances.
Criterion: Comprehensive community based mental health system.
Brief Name: Inpatient Readmissions.
Indicator: Readmission rates.
Measure(s):
 Value 1 Statewide short term readmission rate to CCIS.
 Num: Number of youth readmitted to any CCIS within 30 days.
 Denom: Number of youth discharged from all CCIS.
Sources of Information: Children's Crisis Intervention Service (CCIS) reports. Division of Mental Health Services Unified Services Transaction (USTF) Reports. Division of Child Behavioral Health Services reports. ABCTC reports.
Issues: Over the course of this plan New Jersey will phase down and close the Arthur Brisbane Child Treatment Center, the single remaining state operated inpatient facility for youth. As alternative services are developed to serve this population in the community, fluctuations in CCIS readmission rates are anticipated. DCBHS will monitor readmission rates closely.
Significance: Reduction of hospitalization is a primary goal of the mental health block grant law.

INDICATOR DATA TABLE 1-A

Measure: Inpatient Readmission Rates.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: Statewide 30 Day Readmission Rate to CCIS.	<u>7.0%</u>	<u>=7.0%</u>	<u>=7.0%</u>	<u>=7.0%</u>	

**NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION:
CRITERION 1—MEASURE B**

Goal: Increase community linkage and reduce hospitalization.
Objective: Expand access to case management.
Population: Youth with Serious Emotional or Behavioral Disturbances.
Criterion: Comprehensive community based mental health system.
Brief Name: Case Management.
Indicator: Case Management Utilization.
Measure(s):
 Value1 The number of youth who receive intensive (CMO) care management.
 Value2 The number of youth who receive moderate level case management.
 Value3 30 day CCIS readmission rate of youth receiving intensive (CMO) care management.
 Num: Number of youth in intensive CMO care management readmitted to CCIS within 30 days.
 Denom: Number of youth receiving intensive CMO care management discharged from CCIS.

Sources of Information: Division of Child Behavioral Health Services reports. Children's Crisis Intervention Service (CCIS) reports. Division of Mental Health Services Unified Services Transaction (USTF) Reports.

Issues: As detailed in the Criteria One Overview, New Jersey provides three tiers of case management to address the varied needs of children and families:
Care Coordination provided by the Contracted Systems Administrator for children and families who are able to access and utilize services with minimal support. This level of service is available by telephone only.
Youth Case Management provided by Youth Case Management Programs for children and families who require moderate, face-to-face guidance and support to access and utilize services appropriately.
Care Management provided by Care Management Organizations (CMO) for children and families who require substantial assistance to access and utilize services appropriately.
 Children requiring the most intensive level of case management are at the greatest risk for hospitalization.

Significance: Assuring access to case management is a primary goal of the block grant.

INDICATOR DATA TABLE 1-B

Measure: Case Management.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: Number of youth who receive intensive care management.	<u>1,250</u>	<u>1,500</u>	<u>1,750</u>	<u>2,000</u>	
Value 2: Number of youth who receive youth case management.	<u>3,200</u>	<u>5,000</u>	<u>7,000</u>	<u>9,000</u>	
Value 3: 30 day CCIS readmission rate of youth receiving Intensive care management.	<u>12.9%</u>	<u>=15.0%</u>	<u>=15.0%</u>	<u>=15.0%</u>	

CRITERION 2

Mental Health System Data and Epidemiology

Quantitative targets to be achieved through the implementation of the mental health system, including estimates of the prevalence rates of individuals with SMI and SED in the state and the numbers of SMI and SED individuals to be served, will be specified.

Demographics

Census 2000 data ranked New Jersey ninth in the United States in total population at 8.4 million. 2.1 million residents are under the age of 18. Geographically, New Jersey is one of the smallest states and, at 1,135 people per square mile (the national average is 79.6), it is the most densely populated state. This population density is remarkable when it is understood that 18% of the state's land area is still farmland, 40% is forested, and the largest city, Newark, contains only 300,000 people! Most New Jersey residents live in suburban areas. The median income of New Jersey households with children is \$60,000, almost \$15,000 above the national average.

The following table is based on Census 2000 data and on Division of Mental Health Services utilization data. The total and the percent of New Jersey youth under the age of 18 in each population group is shown. Males account for approximately 51.5% of each group. The numbers served in the mental health system and the percentage is also shown for each group. In an unduplicated count, males account for 47.7% of youth served.

<u>Group</u>	<u>Total Population Under 18</u>	<u>Percent</u>	<u>Number Served in M.H. System</u>	<u>Percent</u>
White	1,240,057	59.4	25,472	49.4
Black/African American	325,831	15.6	14,203	27.5
Hispanic	338,794	16.2	9,642	18.7
Asian/Pacific Islander	123,833	5.9	448	0.9
Amer. Indian / Alaskan	3,089	0.2	343	0.7
Other	7,038	0.4	862	1.7
Two or More Races	48,916	2.3	---	---
Unknown	---	---	586	1.1
Total	2,087,558	100.0	51,556	100.0

According to "Kids Count New Jersey, State and County Profiles of Child Well-Being 2003", 25% of New Jersey's population is below the age of 18 years old (up 2% since 1997). New Jersey ranks fourth overall nationwide in child well-being. One indicator of youth risk has increased; there are now 23% of children living in single parent households (up 4% since 1997 but 4% below the national average). Other risk factors have leveled off or improved. There are still 15% of children living below the poverty level (no change since 1997 but 5% below the national average). Infant mortality, births to teens, and child and teen death rates have all declined at a pace keeping New Jersey ahead of national trends. A violent crime arrest rate of

467 per 100,000 (down from 696 per 100,000 in 1997) for youth ages 10-17 still places New Jersey among the higher states in this category.

Since 1990, the number of acute inpatient admissions to Children's Crisis Intervention Services has steadily increased from under 3,000 to 4,500 per year while the average length of stay has decreased from 28 to 10 days statewide. With a shorter length of stay in an acute setting, pre-discharge planning, linkage, and the provision of suitable aftercare for youth and their families has become even more vital.

Estimate of the Prevalence of Serious Emotional Disturbance

Using the federal methodology for estimating the prevalence of SED among children and adolescents and selecting eight percent, the midpoint of the two ranges of SED presented in the methodology, which are based on level of functioning, yields an estimate of youth with SED in New Jersey of 74,614. This youth between the ages of eight and eighteen with a GLOF of 55. The Division of Child Behavioral Health Services recognizes that the federal estimation methodology does not take into account youth between birth and eight. However, DCBHS considers the five to eight age group in planning the Child Behavioral Health Services System and will be developing strategies with the Division of Prevention and Community Partnership to identify youth at risk under the age of five and to make appropriate services available.

New Jersey experienced a 21.7% increase in children under five from 1980 to 2000. The number of children from 14 to 17 years of age increased 7.5% from 1990 to 2000. This age group is expected to increase 20% by 2010. The number of young adults aged 18 to 24 is also expected to increase by 33.6% by 2010. The Child Behavioral Health Services System is planning ahead to develop services for these age groups.

**NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION:
CRITERION 2—MEASURE A**

Goal: Assure access to behavioral health services.
Objective: Maintain or increase access to publicly funded services.
Population: Youth with Serious Emotional or Behavioral Disturbances.
Criterion: Behavioral health system data epidemiology.
Brief Name: Service Utilization and Mobile Response Service Development.
Indicator: Service admissions of youth with SED.
Measure(s):
 Value 1 The number of service admissions of youth with SED.
 Value 2 The number of youth who receive Mobile Response and Stabilization Services.
 Value 3 The number of counties with Mobile Response and Stabilization Services.
 Value 4 The number of youth admissions to Treatment Home Services.
Sources of Information: Division of Child Behavioral Health Services Reports. Children's Crisis Intervention Service reports. Division of Mental Health Services Unified Services Transaction (USTF) reports.
Issues: To estimate the actual number of youth with SED served in the mental health system, the Global Level of Functioning Scale (GLOF) is used. Youth with a GLOF of 1 through 5 are included in the SED category. Treatment Homes are New Jersey's approach to Therapeutic Foster Care, a recognized Best Practice for children.
Significance: Ensuring access to the public behavioral health system is a key requirement of the block grant law.

INDICATOR DATA TABLE 2-A

Measure: Service Utilization and Mobile Response Service Development.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: The number of service admissions of youth with SED.	<u>13,350</u>	<u>14,000</u>	<u>14,500</u>	<u>15,000</u>	
Value 2: The number of youth who receive Mobile Response and Stabilization Services.	<u>1,500</u>	<u>1,750</u>	<u>2,000</u>	<u>2,500</u>	
Value 3: Number of Counties with Mobile Response and Stabilization Services.	<u>12</u>	<u>15</u>	<u>18</u>	<u>21</u>	
Value 4: The number of youth admissions to Treatment Homes.	<u>487</u>	<u>500</u>	<u>550</u>	<u>600</u>	

CRITERION 3**Provision of Children's Services**

A statewide system of integrated social, educational, juvenile, and substance abuse services, together with health and mental health services, will be provided so that children with a serious emotional disturbance will receive care appropriate to their multiple needs (including services provided under the Individuals with Disabilities Act).

Coordination of Youth Services

New Jersey's Department of Human Services provides support and comprehensive social services for more than one million adults and children, or about one out of every eight New Jersey residents. The Department operates six psychiatric hospitals (five for adults and one for adolescents), ten centers for developmentally disabled persons, and residential programs for emotionally disturbed youth. It also serves youth and families, administers emergency assistance, TANF, Medicaid, aid to the blind, to the deaf and hearing impaired, as well as other social programs. Services and assistance are provided through nine Divisions and the Office of Education and by various units of the Department's Office of Children, including the Office of Prevention of Mental Retardation and Developmental Disabilities. In 2004, \$10 million in additional funding for substance abuse treatment for mothers with children was provided, and the Division of Addiction Services was moved from the Department of Health and Senior Services to the Department of Human Services, where it will be able to participate more closely with other child-serving Divisions.

The primary State responsibility for mental health services to the target population of youth with serious emotional disturbances lies with the Division of Child Behavioral Health Services within the Department of Human Services. The Division of Youth and Family Services shares in service provision to children and adolescents with serious emotional disturbances through its legislative mandate as the responsible agency within State government for permanency planning and child protective services.

The Division of Child Behavioral Health Services in Trenton is concerned with statewide operations, planning, and program and policy development and Quality Improvement. The Division of Child Behavioral Health Services also retains responsibility for the operation of the forty bed Arthur Brisbane Child Treatment Center (ABCTC), New Jersey's only inpatient state psychiatric facility for youth 11 to 18 years of age. Youth under 11 years of age are served in small, community facilities as an alternative to intermediate and long term inpatient hospitalization. During this plan cycle, ABCTC will be closed and its services will be provided in alternative settings. Community-based Children's Crisis Intervention Services inpatient units and post-inpatient psychiatric community residences are located across the state. These facilities admit youth from a defined sub-regional service area to assure that youth are hospitalized as close to their home as possible and to facilitate linkage back to the community.

Each county has a County Inter-Agency Coordinating Council (CIACC) and several retain Case Assessment Resource Teams (CART). Although the CIACCs will continue to play a role following the full implementation of the Child Behavioral

Health Services System, the remaining CARTs will be gradually phased out as the CMOs assume responsibility for individual service planning and integration at the local level.

During our transition to a new system of care, while 15 Service Areas are developed, DCBHS staff are working with the Regional Children's Coordinating Councils, family members, service providers, county governments, and other child-serving agencies to ensure interdivisional and Departmental cooperative planning and service provision for youth with SED. Regional Children's Coordinating Councils continue to focus on regional and multi-county issues impacting system, policy, and operational areas. As New Jersey moves from a regional system to a more localized system, new Service Areas (which match the Superior Court vicinages, the CMO service areas, and the new Division of Youth and Family Services Area Offices) will play a critical role in the development of smaller, more efficient, integrated localized service networks.

During the next three years, the child-serving Divisions of the Department of Human Services, in partnership with other divisions and departments serving children, will continue to reshape a complex set of existing policies, institutions, service systems, and agencies into a more integrated and effective seamless community-based system of care. Shifting from a reliance on more restrictive, out-of-home treatment settings to community-based services by focusing on the needs of children and families, while emphasizing family preservation and support, will continue to be a priority.

Child Behavioral Health Services System Reform

Despite the existence of many excellent programs and providers in New Jersey, the service system did not always meet the needs of children with emotional and behavioral disturbances and their families adequately, especially those with complex needs who were involved with a number of child-serving systems. Children and families needed more flexible, community-based services that were locally managed and coordinated as an organized system of care. The Youth Incentive Program, which began in 1990, partially addressed this issue through a wraparound process for limited numbers of youth with emotional disturbance, but the Case Assessment Resource Teams (CARTs) that were created under this program did not have sufficient funding or authority to overcome the inherent barriers of a segmented service system.

The Department of Human Services realized that to achieve the level of flexibility and coordination individual youth and families needed would require major structural reform of the service system. In 2001 DHS launched the Children's System of Care Initiative (now called the Child Behavioral Health Services System) to implement a new system of care that would significantly change the financing, contracting, organization, and delivery of services for children and families in New Jersey.

The Child Behavioral Health Services System is a reform initiative, not a cost savings initiative. New revenue has been introduced, and services are being expanded. There are no financial incentives to limit access and utilization of care. The goal is improvement of the system of care for youth with emotional and behavioral disturbances and their families by providing them with the right services, in the right place, at the right time.

In January 1999, plans to restructure the systems that serve children with emotional and behavioral disturbances required an initial commitment to increase spending for treatment significantly over several years. In SFY 2001, \$39 million and in SFY 2002 \$48 million in new combined state and federal funding was added to the total expenditures to increase community-based treatment and to launch the dramatic reworking of how children's services were funded and coordinated. In subsequent years total expenditures were increased to continue service expansion and the development of Child Behavioral Health Services System (to \$201 million in SFY 2003 and \$211 million in SFY 2004). The total expenditure for the Child Behavioral Health Services System for SFY 2005 will be \$305 million. Funding is expected to continue to increase as the reforms are implemented over the next several years.

The principal elements of the Child Behavioral Health Services System include:

- building culturally competent, individualized service plans to meet the needs of the child and giving families a greater say in their child's treatment.
- expanding the array of services available to children in their own homes and communities;
- creating a comprehensive and accountable management system to manage and coordinate care across systems;
- increasing funding for services;

The Child Behavioral Health Services System is being phased in, with the new system expected to be fully in place statewide in three to four years. The Child Behavioral Health Services System covers all children with emotional and behavioral disturbances who enter publicly funded systems, including child welfare, mental health and juvenile justice, from ages 0-18, as well as youth 18-21 who may be transitioning to the adult system. The Initiative calls for pooling resources from Child Welfare, Mental Health and Medicaid, investing in new resources and managing those resources so that services are expanded and tailored to meet the needs of each individual child and family. By establishing a statewide system to register and track children, the state will be better able to ensure service coordination for children with multiple needs. Service plan data is facilitating the development of a comprehensive quality assurance and performance improvement program.

The following are the highlights of the Child Behavioral Health Services System:

- Expanding and redistributing funds for children's services in a way that places greater emphasis on meeting children's needs earlier by providing a wider array of services delivered in the home or in the child's community.
- Preserving the child's ties to family, school and community and inviting families to be partners in planning for the child's services by including the development of independent family-run Family Support Organizations under contract with the Department of Human Services to provide family support and foster active participation in treatment planning and at all levels of systems planning, monitoring and quality improvement.
- Pooling resources currently supporting many children's programs—in the Child Welfare, Mental Health and Medicaid budgets—and managing those resources so that services are expanded and can be tailored to the individual child.

- Offering children and families quick access to a broader array of services and resources than are currently available and inviting families to participate in developing their child's treatment plan and services to meet the child's and families' needs.
- Requiring all child-serving agencies to utilize common screening and assessment tools and establishing a virtual single point of entry by creating an overarching information system that registers, tracks and coordinates care for children who are screened for services.
- Establishing local Care Management Organizations (CMOs) to identify, arrange, and assure the provision of local services and community resources for children requiring the most intensive services. While the CMOs plan and manage services, they have no financial incentive to restrict care.
- Increasing overall funding for the children's system of care by dramatically increasing state funding and increasing the amount of federal funds for which the state is eligible under Medicaid.

The Child Behavioral Health Services System gives families an easier way to access mental health services. These reforms and system development will augment existing intensive inpatient and residential services and fill gaps in early intervention and community-based services that will help children function in their homes, schools and communities. The Child Behavioral Health Services System manages behavioral health services more effectively and expands the range of services available for children and families. When complete, it will close gaps in the current system and give families real options when they need them most.

Components of the Child Behavioral Health Services System

The Children's System of Care operates under the paradigm of an organized system of care, providing individualized, community-based services and social supports, organized under a single service plan tailored to the needs and strengths of the individual child and family. This requires new approaches to financing, contracting, managing, and delivering services to assure capacity and accountability for delivering care under this paradigm.

The Department of Human Services provides direction and administrative support for developing capacity and accountability by:

- Assuring effective integration of policy, resources and procedures among child-serving systems through ongoing collaborative planning and system management.
- Assuring access to specialized services for children and families involved with the court through service agreements with the Courts, Probation and the Juvenile Justice Commission (JJC) for intersystem communication and the timely exchange of relevant information, including comprehensive assessments.
- Providing training and consultation to ensure full family participation, build provider capacity and ensure the development and delivery of quality services.
- Re-aligning services and programs operated by the Department to function and be accountable as participating members in the new system of care. The role

and mission of these programs and facilities will change over time to support a unified managed continuum with the flexibility to provide individualized care, services and payment mechanisms.

- Implementing service expansion to enable the organization and delivery of services to support outcomes-based Individual Service Plans (ISPs).
- Reviewing trends and analyzing data to provide an empirical base for system planning and evaluation consistent with child, family and community needs and strengths.

In addition to these changes at the DHS level, the Child Behavioral Health Services System required new system capacity for:

- Coordinating system of care access and service utilization.
- Developing and implementing Individual Service Plans across child-serving systems.
- Effectively organizing consistent family and community participation in planning and service delivery.

To create the capacity to carry out these functions in the new system, three new organizational entities have been developed. They are:

- **Care Management Organizations (CMOs)** to organize and coordinate community-based services and informal resources through face-to-face care management at the local level for individual children and families with multi-service needs and multi-system involvement. Ten CMOs are already in place and five more are planned to be phased in during this plan cycle.
- **Family Support Organizations (FSOs)** to provide direct peer support and assistance to children and families from family members of children with current system involvement. Ten FSOs are in place, developed concurrently with the CMOs. Five more FSOs are planned, with a new FSO developed with each new CMO.
- **A Statewide Contracted System Administrator (CSA)** to support utilization management, care coordination, quality management, and information management for the statewide system of care. The CSA provides information needed to manage the Individual Service Planning process toward quality outcomes and cost effectiveness. The CSA is fully operational.

These new organizations and functions are interdependent system partners in the reform agenda, contracted and managed directly by DHS. Their functions are linked to statewide service expansion, and they will work closely with the DHS, providers, and with each other to enhance, expand, and reorganize the existing system.

Child Behavioral Health Services System Outcomes

The system of care described above is intended to be accountable for concrete outcomes that reflect the Department of Human Services' commitment to maintaining ties among children, families, and communities while delivering

effective clinical care and social support services for children with emotional and behavioral disturbance. Desired outcomes include:

- Improved clinical outcomes and emotional/ behavioral stability.
- Improved permanency in community placements.
- Reduced lengths of stay in residential care.
- Reduced re-admissions to acute psychiatric hospitals.
- Improved crisis management and stability in living environments for families and caregivers.
- Improved educational performance and overall social functioning for children.
- Reduction in delinquent behavior among youth involved with services
- Improved satisfaction and increased participation in treatment by families and children.

In addition to these global outcomes, each child and family's individual service plan will target specific functionality in major life domains.

Child Behavioral Health Services System Implementation Advisory Committee

As the statewide Child Behavioral Health Services System unfolds, the Statewide Implementation Advisory Committee has assumed the leadership role formerly filled by the Children's Coordinating Council. This 40-person group meets monthly to provide input on the implementation of the initiative and to assist the Department of Human Services (DHS) in developing strategies to ensure the reform goals will be met. The Committee is co-chaired by the Deputy Commissioner of DHS and the Executive Director of the Mental Health Association of New Jersey. It includes representation from the State Mental Health Board and the Planning Advisory Council, providers, advocates, families, clergy and related government agencies: the Division of Youth and Family Services, Division of Mental Health Services, Medicaid, Juvenile Justice Commission, Administrative Office of the Courts, Division of Addiction Services, and the Department of Education.

The Traumatic Loss Coalitions Project

In New Jersey, as in other states in recent years, traumatic events involving youth have occurred which called dramatic attention to the need for systematic crisis intervention after such events. The need to develop ongoing response mechanisms in coordination with school districts for meeting these needs in a proactive way is especially important. Coordinating these efforts with New Jersey's 616 local school districts requires county planning and local preparedness. Towards this end, the Division of Child Behavioral Health Services has dedicated \$0.5 million of the Children's Mental Health Block Grant allocation annually to fund the development and activities of traumatic loss coalitions at the county level.

The major goals of the Traumatic Loss Coalitions (TLC) project are to identify and train a network of professionals in each county to identify and systematically

address issues related to mental health emergencies for youth subsequent to trauma and to provide mental health professionals with training that reflects the current knowledge base about the mental health needs of the community subsequent to traumatic incidents involving youth. The coalitions will create a comprehensive, developmentally and culturally sensitive, family friendly model that is responsive to the continuum of needs from prevention through treatment and postvention to youth at-risk subsequent to traumatic youth death and other traumatic losses. Key stakeholders in each county, such as school superintendents and administrators, mental health providers, county prosecutors and other law enforcement officials, health officers, clergy, and others participated in concept development forums in twenty counties during the year preceding initiation of the Traumatic Loss Interventions for Youth Project.

One county, which had experienced several traumatic events in recent years, developed a coalition which has served as a successful demonstration model for aspects of the TLC project. Using funds from the block grant, coalitions were developed in five additional counties in the first year of the project. Coalition development was accelerated following the events of 9/11/2001. All Coalitions are fully functional and will be developing and refining local response networks during this plan cycle.

Description of Activities Related to the Individuals with Disabilities Act (IDEA) for Children.

The New Jersey Department of Education, Office of Special Education Programs, ensures compliance with the statutory requirements of the Individuals with Disabilities Education Act for all New Jersey students with disabilities, from age three to twenty-one, who receive educational services in the state. The Department of Education guarantees that a free and appropriate education is provided to youth with disabilities, including youth with serious emotional and behavioral disturbances.

The New Jersey Department of Human Services' (DHS) Office of Education serves children who are clients of one of the Divisions of DHS, either in the institutions in which they reside or at one of 18 Regional Schools staffed by specially trained administrators, teachers and aides. The Office of Education serves almost 2,400 children and young adults annually with an operating budget in excess of \$60 million.

The Office of Education provides an education for two different groups of children and young adults who require intensive educational services and support that are not available to them through the public school system. These two groups are:

- Children and young adults from 3 through 21 who reside in Department of Human Services facilities or who live in the community and are clients of one of the divisions of the New Jersey Department of Human Services.
- Teenagers and young adults who have been referred to Office of Education programs under arrangements with local school districts, county government, other state agencies or the federal government.

The Office of Education's 843 employees serve these young people in either the state facilities or residential centers in which they live, one of 18 Regional Schools or in other state-operated or leased sites, such as classrooms in public school buildings. All programs operate year-round. The goal of each program is to

provide the children with the basic educational, vocational, work readiness, social and life skills they will need to live as independently as possible as adults.

The Office of Education also administers the NJ Technical Assistance Program (TAP) for children ages 3 through 21 who have difficulty with hearing and vision . and the Technology for Life & Learning Center (TLLC), which assists people with disorders that affect their ability to communicate. These are the main programs offered by the Office of Education:

- Regional School and Institutional programs for DHS clients.
- The Teen Education and Child Health Project (TEACH) operates in Atlantic, Mercer, Warren and Cape May counties and provides individualized education programs and support services for teens who are pregnant or are parenting babies.
- The New Jersey Youth Corps, operating at 13 sites, offers young adults ages 16 to 25, who have left school before earning a diploma, the opportunity to earn their GED and develop marketable skills through community service projects.
- AmeriCorps is part of a national Peace Corps program created by Congress that offers young people age 17 and up the chance to serve their communities in exchange for college financing or training, or to help repay a student loan. Five of the 17 AmeriCorps sites in New Jersey are located at New Jersey Youth Corps locations.
- The Alternative Transitional School serves youth between 13 and 21 who are referred because of their involvement with the juvenile justice system and who need specialized instruction and support to prepare them for work or to return to school.

Specialized programs in institutions and residential centers:

The Office of Education provides educational services for children with developmental disabilities, which include mental retardation, cerebral palsy, spina bifida, epilepsy and other neurological impairments, and who are placed by the Division of Developmental Disabilities in state facilities and out-of-state private residential centers. The educational instruction is integrated into the rest of the child's treatment program so that his or her total needs are met in a consistent and comprehensive manner.

Programs in Regional Schools:

Each of the Office of Education's 18 Regional Schools offers individualized, comprehensive year-round programs designed to meet the educational and psychological needs of students with moderate and severe cognitive impairments, multiple disabilities, autism, behavioral or emotional disturbances and other disabilities who cannot be served in the public school system. These children are clients of either the Division of Developmental Disabilities, the Division of Child Behavioral Health Services or the Division of Youth and Family Services.

In addition to their educational program, children receive child study, clinical and rehabilitative services. School staff also take steps to make sure the child makes a successful transition when they leave the school and move on to school, work and

family. Some Regional Schools also house other programs offered by the Office of Education, specifically Project TEACH and The Alternative Transitional Education Program.

Cooperation with the Department of Education

Representatives from the Department of Education (DOE) serves on the Mental Health Planning Advisory Council, the Child Behavioral Health Services System Implementation Advisory Committee and the Children's Mental Health Planning Committee. This council member brings much needed expertise on the needs of youth receiving special education services to the Planning Council and the Planning Committee.

A training video called "Students at Risk for Suicide—Assessment and Interview Techniques" was developed in cooperation with the University of Medicine and Dentistry of New Jersey's Technical Assistance Center. The video, which presents realistic interview scenarios between school clinicians/counselors and grammar, middle and high school students at risk, provides clear interview and follow-up guidelines that are also suitable for counselors in other settings. Following the assessment, the video covers how to arrange for professional mental health services and how to notify parents and enlist their cooperation. The video has been widely distributed to New Jersey schools.

The Division of Child Behavioral Health Services continues to develop a partnering process with the Department of Education by sharing information about services and service utilization. The Department of Education has also agreed to join the Department of Human Services' Divisions and the Juvenile Justice Commission in sharing training opportunities across the youth serving community. The Department of Human Services collaborated with the Department of Education's grantee, the Richard Stockton College of New Jersey, in the development of a model for the establishment and coordination of violence prevention, intervention and postvention strategies for local school districts in Atlantic County. This collaboration focused on areas where the Department of Education Safe Schools and Safe Communities Grant and the Traumatic Loss Interventions for Youth Project could be mutually supportive.

Cooperation with the Juvenile Justice Commission.

The Division of Child Behavioral Health Services has formed cooperative relationships with the Juvenile Justice Commission, especially with the Office of Special Needs Populations. The Juvenile Justice Commission is represented on the Planning Advisory Council, the Child Behavioral Health Services System Implementation Advisory Committee, the Clinical Advisory Utilization Management Committee, the Quality Assurance Performance Improvement Committee and the Children's Mental Health Planning Committee. The exchange of data between mental health and juvenile justice and the commitment to monitor service access and utilization are reflected in the measures in this plan.

Cultural Competence

Each year cultural competence self-assessments are completed by different programs representing services in each of the state's regions in both urban and rural counties. Using an instrument developed by the Department of Human Services, staff at all levels identify areas where their programs could become more

culturally competent, often with minimal additions or expense. Each of the programs is then offered technical assistance in the form of two-day cultural competence workshops designed to support them in their efforts to improve this important aspect of their services.

To promote cultural competence in the Child Behavioral Health Services System, the requirements for Care Management Organization and Family Support Organization development specify that each have a Board that includes a minimum of 1/3 family members whose children are current or recent clients of the existing systems serving this population, and that representation be reflective of the CMO area's cultural and ethnic diversity.

NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION: CRITERION 3—MEASURE A

Goal: Support youth in their own homes and communities.

Objective: To decrease the reliance on out of state residential placements.

Population: Youth with Serious Emotional or Behavioral Disturbances.

Criterion: Children's services.

Brief Name: Out of State Placement.

Indicator: Incidence and duration of out of state residential placement.

Measure(s):

Value 1 Percent of youth receiving DCBHS services who are placed in out of home treatment settings.

Num: Number of enrolled youth in out of home placement.

Denom: Number of youth enrolled.

Value 2 Percent of youth receiving intensive care management services who are placed in out of home treatment settings.

Num: Number of CMO youth in out of home placement.

Denom: Number of youth receiving CMO services annually.

Value 3 Average LOS in out of state placement of DCBHS enrolled youth.

Num: Total days in placement of DCBHS enrolled youth.

Denom: Number of DCBHS enrolled youth out of state placement.

Sources of Information: Division of Child Behavioral Health Services Reports.

Issues: As the Division of Child Behavioral Health Services matures, the number and LOS of these placements is expected to decrease over time. However, as services are expanded into the remaining counties, an initial increase in the number of youth requiring out of home or out of state placement may result.

Significance: The provision of services in the community to avoid the need for placements that distance youth from their family and their community is a primary goal of the block grant.

INDICATOR DATA TABLE 3-A

Measure: Out of State Placement.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: Percent of youth receiving services who are placed in out of home placement.	<u>36%</u>	<u>35%</u>	<u>30%</u>	<u>25%</u>	
Value 2: Percent of youth receiving intensive care management services who are placed in out of home placement.	<u>23%</u>	<u>22%</u>	<u>20%</u>	<u>=20%</u>	
Value 3: Average LOS (days) in out of state placement of DCBHS enrolled youth.	<u>335</u>	<u>330</u>	<u>325</u>	<u>320</u>	

NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION: CRITERION 3—MEASURE B

Goal: Provide comprehensive behavioral health and support services for youth and their caretakers to avoid placement disruption.

Objective: To promote living situation stability.

Population: Youth with Serious Emotional or Behavioral Disturbances.

Criterion: Children's services.

Brief Name: Stable Family Environment.

Indicator: Stability of Living Arrangement.

Measure(s):

Value 1: Percent of youth with SED receiving publicly funded behavioral health services who are able to remain in their current living situation as a result of receiving Mobile Response and Stabilization Services.

Num: Number of youth receiving Mobile Response and Stabilization who are retained in their current living situation.

Denom: Number of youth receiving Mobile Response and Stabilization Services.

Sources of Information: Division of Child Behavioral Health Services reports.

Issues: "Stable living situation" includes youth living with their biological parent(s), legal guardian, adoptive parent(s), foster parent(s), or person acting in the place of a parent such as the person with whom the child or children legally resides and/or a person legally responsible for the child's welfare. Mobile Response and Stabilization Services also respond to youth in out of home residential and other placements to provide services in concert with placement staff to avoid placement disruption. As the Division of Child Behavioral Health Services expands services, out of home placement rates are expected to decline gradually.

Significance: A comprehensive system of care must strive to keep families together.

INDICATOR DATA TABLE 3-B

Measure: Stability of Living Arrangement.

	National Standard	SFY '05 Target	SFY '06 Target	SFY '07 Target
Value 2: Percent of youth who are maintained in a stable living Situation as a result of receiving Mobile Response and Stabilization Services.	<u>85%</u>	<u>>85%</u>	<u>>85%</u>	<u>>85%</u>

NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION: CRITERION 3—MEASURE C

Goal: Provide services for youth that are non-stigmatizing and strength based.

Objective: Provide services in the least restrictive setting.

Population: Youth with emotional or behavioral disturbances and youth with special educational needs.

Criterion: Children's services.

Brief Name: Provision of Education.

Indicator: School enrollment and special education services.

Measure(s):

Value1: Percent of youth receiving publicly funded behavioral health services reporting improvement in school or work.

Num: positive responses to MHSIP youth survey item # 20.

Denom: Total number of responses.

Value2: Percent of parents of youth receiving publicly funded behavioral health services reporting improvement in their child regarding school or work.

Num: Positive responses to MHSIP parent survey item # 20.

Denom: Total number of responses.

Sources of Information: Division of Child Behavioral Health Services reports.

Issues: Baselines of MHSIP measures are estimated from preliminary survey data. MHSIP survey still in process at time of plan submission. Baselines will be updated upon completion of the survey.

Significance: The provision of behavioral health services as part of a comprehensive system of care must include consideration of the need to maintain each youth's educational activities during treatment. Education and Behavioral Health share common goals.

INDICATOR DATA TABLE 3-C

Measure: Percent of Parents and Youth Served Reporting Improvement in School or Work.

	SFY '04 <u>Baseline*</u>	SFY '05 <u>Target</u>	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>
Value 1: Percent of Youth Served Reporting Improvement.	<u>59%</u>	<u>60%</u>	<u>65%</u>	<u>70%</u>
Value 2: Percent of Parents Reporting Improvement.	<u>52%</u>	<u>55%</u>	<u>60%</u>	<u>65%</u>

*Estimated. See note in Issues above.

**NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION:
CRITERION 3—MEASURE D**

Goal: Provide access to behavioral health service for youth with juvenile justice involvement.

Objective: To report and develop data on youth with juvenile justice involvement.

Population: Youth with Serious Emotional or Behavioral Disturbances.

Criterion: Children's services.

Brief Name: Youth with Juvenile Justice Involvement.

Indicator: Access to services.

Measure(s):

Value 1 The percent of enrollees to new Care Management Organizations from the juvenile justice system.

Num: Number of enrollees from juvenile justice system to new Care Management Organizations.

Denom: Number of enrollees to new Care Management Organizations.

Value 2 Percent of youth receiving publicly funded behavioral health services reporting no new involvement with juvenile justice.

Num: Positive responses to MHSIP youth survey item # 23.

Denom: Total number of responses.

Value 3 Percent of parents of youth receiving publicly funded behavioral health services reporting no new involvement by their child with juvenile justice.

Num: Positive responses to MHSIP parent survey item # 23.

Denom: Total number of responses.

Sources of Information: Division of Mental Health Services Unified Services Transaction reports (USTF) and CCIS reports.

Issues: As the Division of Child Behavioral Health Services expands services, admissions are expected gradually to decline. These measures may require adjustment as phase in progresses in the various CMO services areas. Baselines of MHSIP measures are estimated from preliminary survey data. MHSIP survey still in process at time of plan submission. Baselines will be updated upon completion of the survey.

Significance: A comprehensive system of care must serve youth with juvenile justice involvement.

INDICATOR DATA TABLE 3-D

Measure: Juvenile Justice Access to Services.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: Percent of enrollees to new CMO's from juvenile justice system	<u>31%</u>	<u>30%</u>	<u>30%</u>	<u>30%</u>	

Measure: Percent of Parents and Youth Served Reporting No New Involvement with Juvenile Justice System.

	SFY '04 <u>Baseline*</u>	SFY '05 <u>Target</u>	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>
Value 2: Percent of Youth Served Reporting no New Involvement.	<u>79%</u>	<u>80%</u>	<u>=85%</u>	<u>=85%</u>
Value 3: Percent of Parents Reporting No New Involvement.	<u>74%</u>	<u>75%</u>	<u>80%</u>	<u>=85%</u>

*Estimated. See note in Issues above.

**NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION:
CRITERION 3—MEASURE E**

Goal: Promote cultural competence in youth services.
Objective: Increase awareness of the need for cultural competence.
Population: Youth with Serious Emotional or Behavioral Disturbances.
Criterion: Children's services.
Brief Name: Cultural Competence.
Indicator: Cultural competence self assessments.
Measure(s):
 Value1 The number of cultural competence assessments completed within the youth serving system.

Sources of Information: Cultural competence self assessment survey reports.

Issues: New Jersey's population is diverse. Services for youth and their families are enhanced when ethnic and cultural differences are part of service planning and delivery.

Significance: A community based system of services must be sensitive to the needs of diverse populations.

INDICATOR DATA TABLE 3-E

Measure: Cultural Competence.

		SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: Number of cultural competence surveys by DCBHS, DYFS, Juvenile Justice, and DOE.		<u>6</u>		<u>8</u>	<u>8</u>	<u>8</u>

NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION: CRITERION 3—MEASURE F

Goal: Continue reform of the system serving youth and their families.

Objective: Complete the development of Family Support Organizations.

Population: Youth with Serious Emotional or Behavioral Disturbances.

Criterion: Children's services.

Brief Name: Family Support Organizations.

Indicator: Complete FSO development in all DCBHS service areas.

Measure(s):
Value1 The number of Family Support Organizations.

Sources of Information: Division of Child Behavioral Health Services reports.

Issues: Fifteen Family Support Organizations serving all twenty-one counties are planned. The first three began serving families early in 2001, paralleling the development of the first three CMOs. Seven more FSOs were added in conjunction with the next seven CMOs. The development of additional FSOs is planned to coincide with the phase in of the remaining CMOs.

Significance: The development of Family Support Organizations in all Care Management Organization areas is a central component of the Child Behavioral Health Service System.

INDICATOR DATA TABLE 3-F

Measure: Development of Family Support Organizations.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: Number of Family Support Organizations.	<u>10</u>	<u>12</u>	<u>14</u>	<u>15</u>	

NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION: CRITERION 3—MEASURE G

Goal: Assure parent participation in policy development and program design.

Objective: Monitor and increase opportunities for parent participation.

Population: Youth with Serious Emotional or Behavioral Disturbances.

Criterion: Children's services.

Brief Name: Parent Involvement.

Indicator: Parent of youth with SED involvement in policy and program development.

Measure(s):

- Value1 Number of parents on Care Management Organization's Boards of Trustees.
- Value2 Number of parents on Family Support Organization's Boards of Trustees.
- Value3 Number of parents on the State Planning and Advisory Council.

Sources of Information: Department of Human Services and Division of Child Behavioral Health Services to report.

Issues: Parents ability to participate in policy and planning sometimes changes with individual family circumstances. Accommodation must be afforded to facilitate parent participation in special circumstances and recruitment of new parents must be ongoing.

Significance: The unique perspective of parents who have experienced the capabilities and limitations of the service system first hand must be part of policy development and system planning. Increasing participation of parents of youth currently receiving services was a CMHS Monitoring Review recommendation for New Jersey in past years.

INDICATOR DATA TABLE 3-G

Measure: Parent Involvement.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: Number of parents on Care Management Organization's Boards of Trustees.	<u>36</u>	<u>40</u>	<u>45</u>	<u>50</u>	
Value 2: Number of parents on Family Support Organization's Boards of Trustees.	<u>40</u>	<u>46</u>	<u>52</u>	<u>58</u>	
	FFY '04 <u>Baseline</u>	FFY '05	FFY '06 <u>Target</u>	FFY '07 <u>Target</u>	<u>Target</u>
Value 3: Number of parents on the State Planning Advisory Council.	<u>6</u>	<u>MAINTAIN</u>	<u>MAINTAIN</u>	<u>MAINTAIN</u>	

NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION: CRITERION 3—MEASURE H

Goal:	Assure parent access to support and advocacy.
Objective:	Complete the development of parent support services.
Population:	Youth with Serious Emotional or Behavioral Disturbances.
Criterion:	Children's services.
Brief Name:	Parent Support Groups.
Indicator:	Development of parent support groups.
Measure(s):	
Value 1	The statewide total of parent support group hours provided.
Value 2	The statewide total of peer support hours provided.
Value 3	Percent of families reporting satisfaction with FSO services.
Num:	Positive responses to MHSIP parent survey item # 1, youth survey item #32.
Denom:	Total number of responses.
Sources of Information:	Division of Child Behavioral Health Services reports.
Issues:	This measure assesses DCBHS' efforts to address the need for a statewide support and advocacy network to support individual parents as they navigate the system of care on behalf of their children, and to identify parent leaders who will function as system advocates in addressing policy, procedure and program development needs at the local, regional, and statewide levels. Support group services are available to all parents of enrolled youth. One to one peer support services are available to parents of youth receiving intensive care management. Baselines of MHSIP measures are estimated from preliminary survey data. MHSIP survey still in process at time of plan submission. Baselines will be updated upon completion of the survey.
Significance:	It is important to expand opportunities for parents to participate in parent support, individual child and family advocacy, and systems advocacy activities.

INDICATOR DATA TABLE 3-H

Measure: Parent Support.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: Total number of parent support group hours.	<u>2,611</u>	<u>2,650</u>	<u>2,750</u>	<u>3,000</u>	
Value 2: Total number of peer support hours.	<u>21,216</u>	<u>21,300</u>	<u>21,500</u>	<u>22,000</u>	

Measure: Percent of Parents Reporting Satisfaction with FSO Services.

	SFY '04 <u>Baseline*</u>	SFY '05 <u>Target</u>	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>
Value 3: Percent of families reporting satisfaction.	<u>71%</u>	<u>75%</u>	<u>80%</u>	<u>=85%</u>

*Estimated. See note in Issues above.

NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION: CRITERION 3—MEASURE I

Goal: Continue reform of systems serving youth and their families.
Objective: Complete the development of Care Management Organizations.
Population: Youth with Serious Emotional or Behavioral Disturbances.
Criterion: Children's services.
Brief Name: Care Management Organizations.
Indicator: Continue CMO phase in. Monitor/maintain system.
Measure(s):
 Value 1 The number of Care Management Organizations.
 Value 2 Percent of youth reporting improvement as a result of CMO services.
 Num: Positive responses to MHSIP youth survey items # 17, 18, 19, 21, 22.
 Denom: Total number of responses.
 Value 3 Percent of parents reporting improvement in their child as a result of CMO services.
 Num: Positive responses to MHSIP parent survey items # 17, 18, 19, 21, 22.
 Denom: Total number of responses.
Sources of Information: Division of Child Behavioral Health Services reports.
Issues: Fifteen Care Management Organizations serving all twenty-one counties are planned. The first three were phased in early in 2001 and seven more were added by 2004. Development of the remaining CMOs is expected to continue according to schedule. Baselines of MHSIP measures are estimated from preliminary survey data. MHSIP survey still in process at time of plan submission. Baselines will be updated upon completion of the survey.
Significance: Care Management Organizations are a focal point of system reform at the local level, representing a new way to plan and deliver comprehensive community services to youth and their families who have complex needs.

INDICATOR DATA TABLE 3-I

Measure: Development of Care Management Organizations.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: Number of operational Care Management Organizations.	<u>10</u>	<u>12</u>	<u>14</u>	<u>15</u>	

Measure: Percent of Parents and Youth Served by CMO Reporting Improvement.

	SFY '04 <u>Baseline*</u>	SFY '05 <u>Target</u>	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>
Value 2: Percent of Youth Served Reporting Improvement.	<u>67%</u>	<u>70%</u>	<u>75%</u>	<u>=80%</u>
Value 3: Percent of Parents Reporting Improvement.	<u>62%</u>	<u>65%</u>	<u>70%</u>	<u>=75%</u>

*Estimated. See note in Issues above.

NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION: CRITERION 3—MEASURE J

- Goal:** Increase awareness of traumatic loss events and develop local networks and strategies for prevention and response.
- Objective:** Develop County Crisis Response Networks (CCRN).
- Population:** School aged youth and school personnel.
- Criterion:** Children's services.
- Brief Name:** Traumatic Loss Coalitions (TLC) County Crisis Response Networks.
- Indicator:** Development of County Crisis Response Networks.
- Measure(s):**
- Value 1 The number of Counties with TLC Crisis Response Networks.
 - Value 2 Percent of schools requesting CCRN assistance.
 - Num: Number of schools requesting CCRN assistance.
 - Denom: Number of schools in CCRN counties experiencing a traumatic loss event.
 - Value 3 Percent of schools receiving a timely CCRN response.
 - Num: Number of schools receiving a response within 24 hours.
 - Denom: Number of schools receiving a CCRN response.
- Sources of Information:** TLC Coordinator Reports. Traumatic Loss Initiative for Youth (TLIY) annual report. Behavioral Research and Training Institute reports.
- Issues:** It is expected that school districts will use the CCRN in varying degrees depending on the nature of the traumatic event and the school's internal resources.
- Significance:** It is important to foster county planning and local preparedness by developing ongoing response mechanisms in coordination with school districts for dealing with traumatic events in a proactive way. Mental health resources must be available to schools in order to mitigate post traumatic stress responses and to decrease the possibility of contagion in the event of a violent death. County TLCs will assist each county in developing a core group of mental health and other providers to provide a coordinated response in the aftermath of sudden death or traumatic loss in the school community.

INDICATOR DATA TABLE 3-J

Measure: Traumatic Loss Coalitions County Crisis Response Networks.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>
<u>Target</u>				
Value 1: Number of counties with a CCRN.	<u>4</u>	<u>7</u>	<u>14</u>	<u>21</u>
Value 2: Percent of schools requesting CCRN assistance.	<u>35%</u>	<u>40%</u>	<u>45%</u>	<u>50%</u>
Value 3: Percent of schools receiving a CCRN response within 24 hours.	<u>75%</u>	<u>80%</u>	<u>90%</u>	<u>95%</u>

NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION: CRITERION 3—MEASURE K

- Goal:** Ensure fidelity to the Traumatic Loss Model protocols.
- Objective:** Provide training to County Crisis Response Network members. Measure fidelity to the Traumatic Loss Model.
- Population:** CCRN members serving school aged youth and school personnel.
- Criterion:** Children's services.
- Brief Name:** Traumatic Loss Coalitions (TLC) County Crisis Response Networks Fidelity.
- Indicator:** Completion of training and implementation of fidelity measurement checklist.
- Measure(s):**
- Value 1: The number of CCRN members trained.
 - Value 2: Fidelity rate of CCRN members.
 - Num: Number CCRN member checklist responses indicating fidelity.
 - Denom: Total number of CCRN member checklist responses.
 - Value 3: Fidelity rate of schools not using CCRN.
 - Num: Number TLC coordinator checklist responses indicating fidelity by schools not using CCRN.
 - Denom: Total number of TLC coordinator checklist responses related to schools not using CCRN.
- Sources of Information:** Traumatic Loss Coalition (TLC) Coordinator Reports. TLC annual report. Behavioral Research and Training Institute reports.
- Issues:** Traumatic Loss Coordinators will receive training in the fidelity monitoring tool during the first year of the plan. Second and third year performance targets may be adjusted based upon results during the first year. Note that baseline data does not exist for Values 2 and 3. These are new activities beginning the first year of the plan.
- Significance:** Ensuring adequate responses to traumatic loss events requires that personnel are trained to provide this critical service. Oversight of the methods employed assures the adequacy of the interventions.

INDICATOR DATA TABLE 3-K

Measure: Traumatic Loss Coalitions County Crisis Response Networks Fidelity.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: The number of CCRN members trained.	<u>0</u>	<u>35</u>	<u>50</u>	<u>75</u>	
Value 2: Fidelity rate of CCRN members.	<u>N/A*</u>	<u>85%</u>	<u>90%</u>	<u>95%</u>	
Value 3: Fidelity rate of schools not using CCRN.	<u>N/A*</u>	<u>50%</u>	<u>60%</u>	<u>75%</u>	

* New Activity. Baseline not established.

**NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION:
CRITERION 3—MEASURE L**

- Goal:** Raise awareness of behavioral health issues and suicide potential in school aged children and encourage referral for treatment.
- Objective:** Develop a training program for use by school mental health professionals in the training of school staff, and conduct training for school mental health professionals in the use of the training materials.
- Population:** School aged youth and school personnel.
- Criterion:** Children's services.
- Brief Name:** Traumatic Loss Coalitions Prevention Training Program.
- Indicator:** Completion of training package and implementation training.
- Measure(s):**
 Value 1 The number of school mental health professionals trained in the model.
 Value 2 The number of school staff trained by school mental health professionals.
- Sources of Information:** Traumatic Loss Coalition (TLC) annual report. Reports from school mental health professionals. BRTI reports.
- Issues:** Training materials will be developed so as to be easily used by professionals with varying degrees of experience.
- Significance:** Recognizing that school staff have the most contact with youth, prevention efforts must include school staff and ensure that they receive training in recognizing warning signs and bringing these to the attention of mental health professionals. Using train-the-trainers maximizes the number of staff who can be trained.

INDICATOR DATA TABLE 3-L

Measure: Traumatic Loss Coalitions Prevention Training Program.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: Number of school mental health professionals trained in the model.	<u>0</u>	<u>100</u>	<u>200</u>	<u>300</u>	
Value 2: Number of school staff trained in the model.	<u>0</u>	<u>500</u>	<u>700</u>	<u>900</u>	

NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION: CRITERION 3—MEASURE M

- Goal:** Identify and address the behavioral health needs of youth leaving Juvenile Justice Commission facilities.
- Objective:** With juvenile justice information identifying treatment history and service needs of youth committed to the Juvenile Justice Commission, monitor access to DCBHS services for youth leaving incarceration.
- Population:** Youth with Serious Emotional or Behavioral Disturbances.
- Criterion:** Children's Services.
- Brief Name:** Juvenile Justice Information.
- Indicator:** Development of juvenile justice mental health data.
- Measure(s):**
- Value 1 Percent of JJC committed youth with SED who receive intensive care management upon release from JJC facilities.
- Num: Number of youth enrolled in intensive care management upon release.
- Denom: Number of youth identified as at risk at time of intake.
- Sources of Information:** DCBHS reports. Juvenile Justice Commission Problem Oriented Screening Instrument for Teenagers (POSIT) Mental Health Scale of JJC Intake Assessment Reports.
- Issues:** As the Division of Child Behavioral Health Services expands services, it is expected that over time fewer youth with serious mental health problems will be incarcerated. However, since the service array will not be fully operational until near the end of this three year block grant plan, and since the new behavioral health services impact on this population may be fully realized only in subsequent years as younger youth receive integrated community services and never enter the juvenile justice system, these measures may have to be readjusted and extended for additional years.
- The Juvenile Justice Commission began screening all newly committed youth in late SFY 2004. Therefore baseline data for this measure reflects the percent of youth identified as SED using data previously available for SFY 2004.
- Significance:** Services to youth in juvenile justice is a priority of the block grant.

INDICATOR DATA TABLE 3-M

Measure: Post-Incarceration Juvenile Justice Behavioral Health Services.

	SFY '04 Baseline	SFY '05	SFY '06 Target	SFY '07 Target	Target
Value 1: Percent of JJC committed youth with SED who receive intensive care management upon release from JJC facilities.	<u>29.7%</u>	<u>30%</u>	<u>40%</u>	<u>50%</u>	

CRITERION 4

Targeted Services to Homeless and Rural Populations

Mental health services, including outreach, will be provided to SMI and SED individuals who are homeless, and services will be provided to individuals residing in rural areas.

Services to Homeless Youth

In New Jersey the Division of Youth And Family Services uses the term “homeless” to refer to adults and to families. Youth who voluntarily leave their place of residence without the consent of their parent, legal guardian, or other individual or agency responsible for their care are referred to as “runaways”. Youth who are unaccompanied by an adult but not believed to be runaways are referred to as “stranded”. The Garden State Coalition for Youth and Family Concerns, which represents New Jersey’s youth shelters recognizes “homeless” youth as those without a place of residence where they can receive supervision and care, while “runaways” are youth who are away from home at least overnight through their own actions. The Division of Child Behavioral Health Services provides behavioral health services to all categories of “homeless” youth in New Jersey through its mandated access procedures. It also provides additional services for sheltered youth, including Mobile Response and Stabilization Services for crisis intervention, assessment, and stabilization, mobile outreach for regular group and individual therapies delivered on site, and case management services.

The Division of Child Behavioral Health Services participates in joint efforts with other Divisions in the Department of Human Services and the Department of Community Affairs for state and local planning and the delivery of shelter and support services to homeless youth and their families. Screening/Emergency Services, mobile outreach teams, Children’s Crisis Intervention Services, and case managers provide services to homeless children and adolescents. The Department of Health’s Certificate of Need requirements mandate hospitals to have affiliation agreements with the Department of Human Services for placement assistance of homeless youth. The Division of Child Behavioral Health Services, which designates Children’s Crisis Intervention Services, encourages inpatient units to establish agreements with youth shelters in their service areas.

Homeless and runaway youth are recognized as a priority population by the Division of Child Behavioral Health Services.

Services to Youth in Rural Areas

The Division of Child Behavioral Health Services defines a county as “rural” if, according to US Census figures, 25 percent or more of its population lived in rural areas. Using this definition, six New Jersey counties are considered rural, three on the State’s southwestern border, and three along the northwestern border. This configuration, along the Delaware River, places rural counties in each region—in the North, Warren and Sussex; in the Central Region, Hunterdon; and in the South,

Cape May, Cumberland and Salem. One of the six rural counties is among New Jersey's highest per capita income counties and one is the lowest, illustrating the diverse resources and needs of even this small subset of our 21 counties!

As part of New Jersey's Comprehensive Community Support Model, a full array of children's mental health services is available to all rural counties. These services include but are not limited to inpatient treatment, psychiatric community residences, youth case management, children's partial care, outpatient services and mobile outreach. The Division of Child Behavioral Health Services monitors the adequacy and effectiveness of the acute care system in each region. New measures for the rural counties have been added to this year plan.

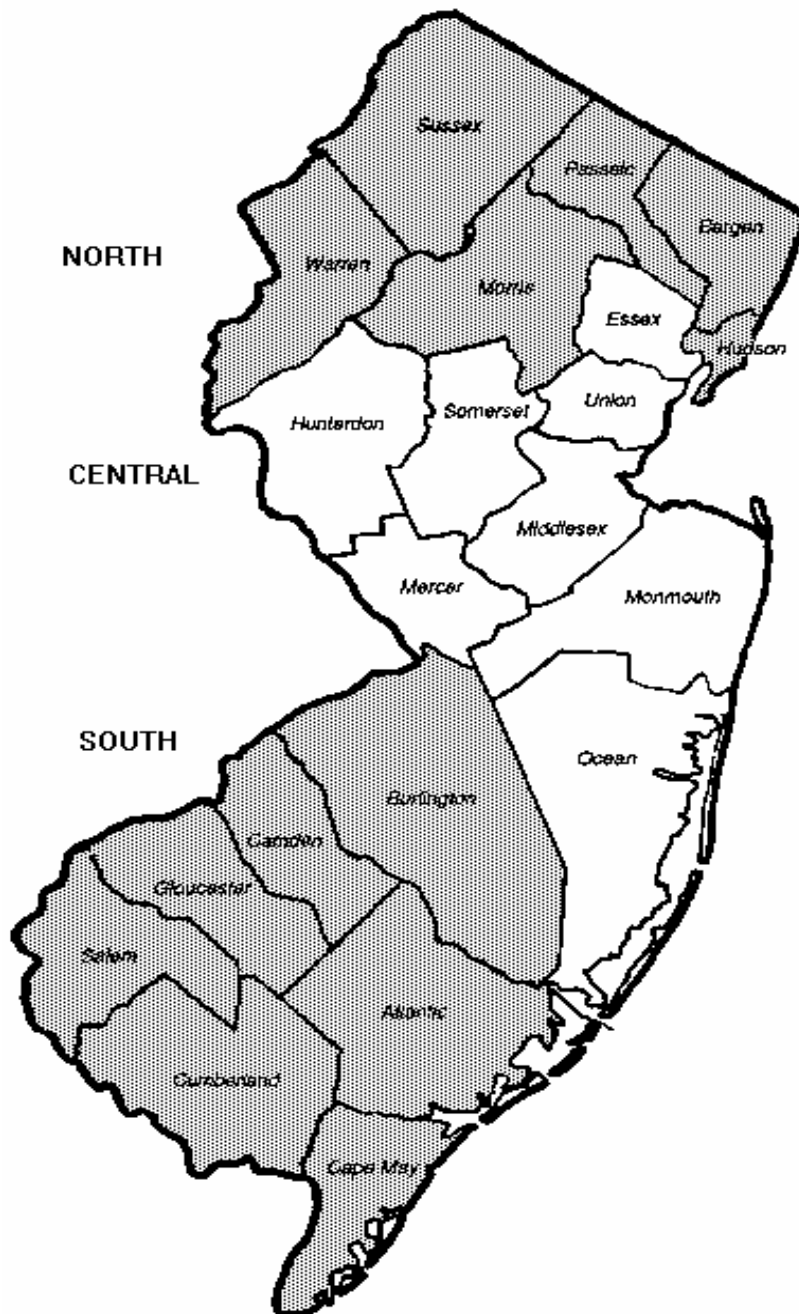
Each county has access to a range of traditional mental health services and each has access to "wraparound" service planning capability. As the Child Behavioral Health Services System is fully phased in, youth in the rural counties will receive behavioral health and support services through that system.

Regional Structure of Youth Services

New Jersey's twenty-one counties remain organized into three Division of Child Behavioral Health Services regions (North, Central and South) and four Division of Youth and Family Services regions (North, Central, Metro, and South). This regional structure will be changed to a new 15 Service Area structure which will encompass behavioral health, child welfare, and the Superior Court vicinages in each area over the course of this plan. Maps of the current regional structure and of the new service areas are included in this plan.

Current Regional Service Areas

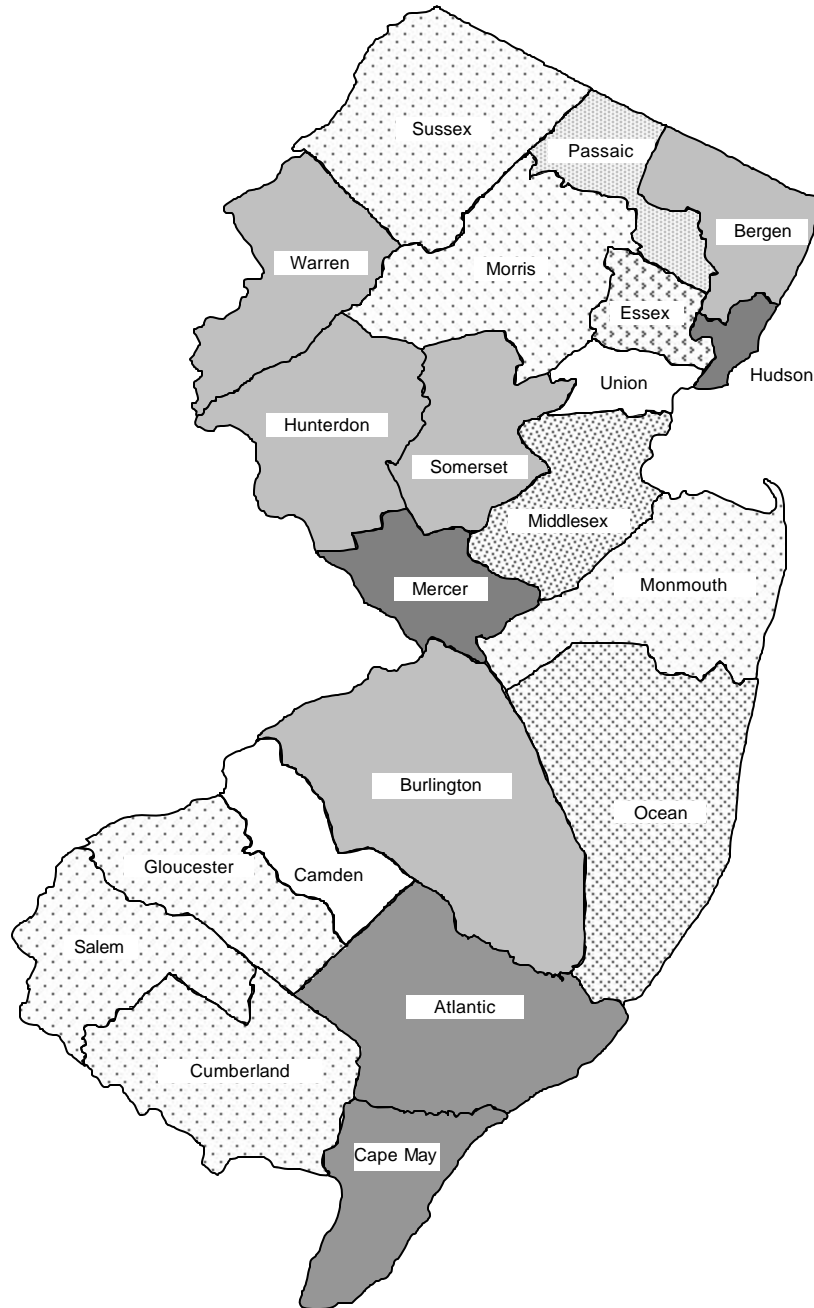
Current New Jersey
Division of Child Behavioral Health Services
Service Regions



New Service Areas

New Jersey's twenty-one counties will be reorganized into fifteen youth service areas during this plan cycle.

New Jersey
Division of Child Behavioral Health Services
New Service Areas



**NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION:
CRITERION 4—MEASURE A**

Goal: Provide behavioral health services to homeless youth.
Objective: Maintain access to services for homeless youth.
Population: Youth with Serious Emotional or Behavioral Disturbances.
Criterion: Services to Homeless and Rural Populations.
Brief Name: Services to Homeless Youth.
Indicator: Service utilization and readmission rate.
Measure(s):
 Value 1 The number of service admissions of youth from homeless shelters or the streets.
 Value 2 The number of youth enrolled in DCBHS services from shelter care.
 Value 3 30 day CCIS readmission rate of youth from shelter care.
 Num: Number of youth from shelters readmitted to any CCIS within 30 days.
 Denom: Number of youth from shelters discharged from all CCIS.
Sources of Information: Division of Mental Health Services Unified Services Transaction (USTF), DCBHS and CCIS reports.
Issues: The number of service admissions of youth from shelters is expected to decline gradually as the Division of Child Behavioral Health Services matures. As Mobile Response and Stabilization and other DCBHS services are expanded into the remaining counties, readmissions to inpatient CCIS units is expected to decline. Value 2 baseline estimated from shelter survey data. DCBHS will track shelter access to DCBHS services directly and update baseline if necessary.
Significance: Access to behavioral health services by homeless youth is important to assure adequate treatment.

INDICATOR DATA TABLE 4-A

Measure: Services to Homeless Youth.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: Number of episodes of service provided for youth from homeless shelters or the streets.	<u>300</u>	<u>350</u>	<u>400</u>	<u>425</u>	
Value 2: The number youth enrolled in DCBHS services from shelter care.	<u>276*</u>	<u>300</u>	<u>350</u>	<u>500</u>	
Value 3: 30 Day Readmission Rate to CCIS of youth from shelter care.	<u>9.1%</u>	<u>9.0%</u>	<u>8.75%</u>	<u>8.5%</u>	

*Baseline estimate.

NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION: CRITERION 4—MEASURE B

Goal:	Assure access to behavioral health services to youth from rural counties.
Objective:	Increase access to services for rural youth.
Population:	Youth with Serious Emotional or Behavioral Disturbances.
Criterion:	Services to Homeless and Rural Populations.
Brief Name:	Services to Rural Youth.
Indicator:	Service utilization by youth residing in rural counties.
Measure(s):	
Value 1	The number of service admissions of youth from rural counties.
Value 2	The number of youth enrolled in DCBHS services from rural counties.
Value 3	30 day CCIS readmission rate of youth from rural counties.
Num:	Number of youth from rural counties readmitted to any CCIS within 30 days.
Denom:	Number of youth from rural counties discharged from all CCIS.
Sources of Information:	Division of Mental Health Services USTF reports and Division of Child Behavioral Health Services reports as the Initiative is phased in.
Issues:	The Division of Child Behavioral Health Services defines a county as "rural" if, according to US Census figures, 25 percent or more of its population lived in non-urban areas. Using this definition, six New Jersey counties are considered rural, three on the State's southwestern border, and three along the northwestern border. This configuration, along the Delaware River, places rural counties in each region - in the North, Warren and Sussex; in the Central Region, Hunterdon; and in the South, Cape May, Cumberland and Salem. One of the six rural counties is among those with the highest per capita income and one is the lowest, illustrating the diverse resources and needs of this subset of the 21 counties. 30 day readmission CCIS readmission rates, which are slightly above the statewide rate, are expected to decline as DCBHS services are expanded to these counties. As the Division of Child Behavioral Health Services expands services, additional county-specific measures may be developed.
Significance:	The provision of services to youth residing in rural areas is a key provision of the block grant law.

INDICATOR DATA TABLE 4-B

Measure: Services to Rural Youth.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: The number of episodes of service provided for youth from rural counties.	<u>6,183</u>	_____	_____	_____	
Value 2: The number youth enrolled in DCBHS services from rural counties.	<u>748</u>	<u>750</u>	<u>800</u>	<u>900</u>	
Value 3: 30 Day Readmission Rate to CCIS of youth from rural counties.	<u>7.5%</u>	<u>7.4%</u>	<u>7.25%</u>	<u>7.0%</u>	

CRITERION 5

Management System

Financial and staffing resources, including human resource development of community mental health providers, will be available to implement the plan, and, the manner in which the state intends to expend the grant for the fiscal year will be described.

Fiscal Summary

The SFY 2005 total Division of Child Behavioral Health Services expenditures from all sources for community mental health services is \$304.8 million. Within this amount, \$22.5 million is earmarked for the development of additional service capability in fulfilling DCBHS's role in New Jersey's Child Welfare Reform Plan. No Block Grant funds are provided for inpatient services in the community, since support for these services is available through other systems.

Please see the Financial Resources section for additional detail on FY 2005 block grant expenditures for community mental health services.

Human Resource Development

In regard to development of staffing resources, the Division of Child Behavioral Health Services funds the Technical Assistance Center through University Behavioral Health Care of the University of Medicine and Dentistry of New Jersey to provide training statewide. The Division of Child Behavioral Health Services will arrange for the provision of specialized training in children's behavioral health issues in each plan year. In recent years as part of the development and implementation of the Child Behavioral Health Services System the Division of Child Behavioral Health Services has provided numerous training opportunities on a wide variety of topics for providers and other system partners as well as mandatory trainings for system components.

Additional Technical Assistance Center training in Youth MICA treatment is offered annually statewide.

Numerous school staff and community participants are trained each year through the Traumatic Loss Coalitions.

The Division of Child Behavioral Health Services makes its training opportunities available to other child serving systems as a way of promoting knowledge the Child Behavioral Health Services System and cooperation across systems.

Over the next three years, the Division of Child Behavioral Health Services will continue its efforts to promote cross-system training with other child-serving divisions and community providers by inviting their participation in Division sponsored training series and other opportunities for staff development and networking and by recognizing and promoting cross training hosted by our child-serving partners in juvenile justice, education, and child welfare. Recognizing the benefits to be derived from the participation of parents, Family Support Organizations are invited to participate in all cross training opportunities.

**NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION:
CRITERION 5—MEASURE A**

Goal: Expand knowledge across the youth serving system.
Objective: Make training opportunities available across the youth serving system.
Population: Youth with Serious Emotional or Behavioral Disturbances.
Criterion: Management Systems.
Brief Name: Specialized Training.
Indicator: The number of behavioral health training opportunities and cross trainings.
Measure(s):
 Value 1 The number of specialized behavioral health trainings offered to at least one geographic region of the state.
 Value 2 The number of cross trainings with other child serving systems, including the Division of Youth and Family Services, the Juvenile Justice Commission, the Division of Child Behavioral Health Services, the Department of Education, and Family Support Organizations.

Sources of Information: DCBHS Technical Assistance Center Reports.
Issues: The Division of Child Behavioral Health Services mandates and provides training to all DCBHS components and providers serving youth and their families. This training is also make available to other child serving systems such as Child Welfare, Juvenile Justice, and Education.
Significance: The provision of training in meeting the unique needs of youth and their families is a stipulation of the block grant law.

INDICATOR DATA TABLE 5-A

Measure: Behavioral Health Training and Cross Training.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: The number of specialized behavioral health trainings offered to at least one geographic region of the state annually by DCBHS.	<u>50</u>	<u>50</u>	<u>50</u>	<u>50</u>	
Value 2: Number of cross trainings with DYFS, JJC, DCBHS, FSOs, DOE and DMHS offered annually.	<u>35</u>	<u>35</u>	<u>35</u>	<u>35</u>	

**NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION:
CRITERION 5—MEASURE B**

- Goal:** Expand knowledge across the youth serving system.
- Objective:** Make training opportunities available across the youth serving system.
- Population:** Youth with Serious Emotional or Behavioral Disturbances.
- Criterion:** Management Systems.
- Brief Name:** Local Training Provided by Traumatic Loss Coalitions.
- Indicator:** The number of staff trained.
- Measure(s):**
Value 1 The number of staff trained by the Technical Assistance Center under the Traumatic Loss Initiative for Youth Project .
- Sources of Information:** Traumatic Loss Coalition Program (TLC) annual report. TLC Coordinator Reports.
- Issues:** The Traumatic Loss Coalition Program provides a variety of training and informational opportunities each year at individual coalition meetings and at regional and sub-regional conferences. Presentations at TLC meetings address needs prioritized by the county responders and school participants. Presentations given at conferences are geared to a regional or statewide audience and deal with topics of interest to a broad array of individuals who must help youth cope with traumatic losses and manage responses to such events in individual and group settings.
- Significance:** The provision of training in meeting the unique needs of youth and their families is a stipulation of the block grant law.

INDICATOR DATA TABLE 5-B

Measure: Local Training Provided by Traumatic Loss Coalitions.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: The number of TLC members and others trained on youth behavioral health and related topics by individual county Traumatic Loss Coalitions each year.	<u>750</u>	<u>750</u>	<u>750</u>	<u>750</u>	

NEW JERSEY CHILDREN'S PERFORMANCE INDICATOR DESCRIPTION: CRITERION 5—MEASURE C

Goal: Increase the quality of services provided for youth and their families.

Objective: To increase the participation of parents in the review of youth behavioral health programs.

Population: Youth with Serious Emotional or Behavioral Disturbances.

Criterion: Management Systems.

Brief Name: Parent Site Review Participation.

Indicator: The number of programs reviewed with FSO parent members.

Measure(s):
Value 1 The number of reviews of youth programs in which Family Support Organization parent members participate.

Sources of Information: Division of Child Behavioral Health Services Bureau of Licensing and Designation reports.

Issues: Parent participation in program review has added immeasurably to the DCBHS review process. This measure has been extended to include the participation of parent members of Family Support Organizations as the FSOs are developed by the Division of Child Behavioral Health Services.

Significance: Input from parents is valuable in judging the appropriateness quality of services. Increasing parent participation was a CMHS Monitoring Review recommendation for New Jersey.

INDICATOR DATA TABLE 5-C

Measure: Parent Participation in Program Evaluation.

	SFY '04 <u>Baseline</u>	SFY '05	SFY '06 <u>Target</u>	SFY '07 <u>Target</u>	<u>Target</u>
Value 1: Number of reviews of youth programs with parent members of Family Support Organizations as reviewers.	<u>6</u>		<u>6</u>	<u>6</u>	<u>6</u>

**APPENDIX A: SAMPLE YOUTH AND FAMILY/CAREGIVER MHSIP
SURVEYS**



New Jersey Child Behavioral Health Services (CBHS)

(Formerly Known as the Partnership for Children)

YOUTH SATISFACTION SURVEY

Please help New Jersey Child Behavioral Health Services (CBHS) make services better by answering some questions about the services you received **OVER THE LAST YEAR**. Your answers are anonymous and will not influence the services you receive. Please indicate if you **Strongly Disagree, Disagree, Are Undecided, Agree, or Strongly Agree** with each of the statements below. Put a cross (X) in the box that best describes your answer. Thank you!!!

Today's Date:

County:

Your CBHS Program Type (Check all that apply):

(See insert for a description and examples of the following)

- ☐ Family Support Organization (FSO)
- ☐ Care Management Organization (CMO)
- ☐ Youth Case Management (YCM)
- ☐ Contracted Systems Administrator (CSA)
- ☐ Mobile Response Stabilization System (MRSS)

- ☐ Behavioral Assistance (BA)
- ☐ Intensive In-Community Services (IIC)
- ☐ Out-of-Home Placement Services (OH)
- ☐ Other:

PLEASE COMPLETE ONLY ONE SURVEY.

	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
1. Overall, I am satisfied with the services I received.					
2. I helped to choose my services.					
3. I helped to choose my treatment goals.					
4. The people helping me stuck with me no matter what.					
5. I felt I had someone to talk to when I was troubled.					
6. I participated in my own treatment.					
7. I received services that were right for me.					
8. The location of services was right for me.					
9. Services were available at times that were right for me.					
10. I got the help I wanted.					
11. I got as much help as I needed.					
12. Staff treated me with respect.					
13. Staff respected my family's faith / spiritual beliefs.					
14. Staff spoke with me in a way that I understood.					
15. Staff was sensitive to my cultural/ethnic background.					
16. I got services in a reasonable amount of time.					



New Jersey Child Behavioral Health Services (CBHS)

(Formerly Known as the Partnership for Children)

YOUTH SATISFACTION SURVEY

As a result of the services my child and/or family received:	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
17. I am better at handling daily life.					
18. I get along better with family members.					
19. I get along better with friends and other people.					
20. I am doing better in school and/or work.					
21. I am better able to cope when things go wrong.					
22. I am satisfied with how my family gets along with each other.					
23. I have stayed free of new police or court involvement.					
24. I would refer a friend for services within DCBHS.					

I am satisfied with the... (Only answer for agencies from which you received services):	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
25. CMO (Care Management Organization)					
26. YCM (Youth Case Management)					
27. CSA CM (Contract Systems Administrator Case Management)					
28. CSA CO (Contract Systems Administrator Care Coordination)					
29. MRSS (Mobile Response Stabilization System)					
30. Out-of-Home Placement Services					
31. BA / IIC (Behavioral Assistance & Intensive In-Community)					
32. FSO (Family Support Organization)					
33. I would refer a friend for services within DCBHS?					

34. What has been the most helpful thing about the services you received over the last year?

35. What would improve the services?



New Jersey Child Behavioral Health Services (CBHS)

(Formerly Known as the Partnership for Children)

YOUTH SATISFACTION SURVEY

36. Your Zip Code: _____ (optional)

37. Your Ethnicity (check one):

- ☐ Asian
- ☐ African American/Black
- ☐ American Indian/Alaskan Native
- ☐ Bi or Multi-Racial
- ☐ White
- ☐ Native Hawaiian/Other Pacific Islander

Are You Hispanic/Latino?

- ☐ Yes
- ☐ No

38. Your Gender (check one):

- ☐ Male
- ☒ Female

39. Your Age (check one):

- ☐ 0 – 4
- ☐ 5 – 10
- ☐ 11 – 13
- ☐ 14 – 17
- ☐ 18 – 21
- ☐ Over 21

40. How long have you been receiving CBHS Services? (check one).

- ☐ Less than 1 month
- ☐ 1 – 2 months
- ☐ 3 – 5 months
- ☐ 6 months to 1 year
- ☐ 1 year to 2 years
- ☐ Over 2 years

Please return this survey to:

3705 Quakerbridge Road,
Suite 116,
Hamilton, NJ 08619

This survey may also be accessed and printed out
from the CBHS Website: www.njkidsoc.org



New Jersey Child Behavioral Health Services (CBHS)

(Formerly Known as the Partnership for Children)

FAMILY SATISFACTION SURVEY

Please help New Jersey Child Behavioral Health Services (CBHS) make services better by answering some questions about the services your child received **OVER THE LAST YEAR**. Your answers are anonymous and will not influence the services you or your child receives. Please indicate if you **Strongly Disagree, Disagree, Are Undecided, Agree, or Strongly Agree** with each of the statements below. Put a cross (X) in the box that best describes your answer. Thank you!!!

Today's Date:

County:

Your Child's CBHS Program Type (Check all that apply):

(See insert for a description and examples of the following)

- ☐ Family Support Organization (FSO)
- ☐ Care Management Organization (CMO)
- ☐ Youth Case Management (YCM)
- ☐ Contracted Systems Administrator (CSA)
- ☐ Mobile Response Stabilization System (MRSS)

- ☐ Behavioral Assistance (BA)
- ☐ Intensive In-Community Services (IIC)
- ☐ Out-of-Home Placement Services (OH)
- ☐ Other:

PLEASE COMPLETE ONLY ONE SURVEY.

	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
1. Overall, I am satisfied with the services my child received.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					
2. I helped to choose my child's services.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					
3. I helped to choose my child's treatment goals.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					



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	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
4. The people helping my child stuck with us no matter what.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					
5. I felt my child had someone to talk to when he/she was troubled.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					
6. I participated in my child's treatment.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					
7. The services my child and/or family received were right for us.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					
8. The location of services was right for us.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					



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	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
9. Services were available at times that were right for us.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					
10. My family got the help we wanted for my child					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					
11. My family got as much help as we needed for my child					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					
12. Staff treated me with respect.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					
13. Staff respected my family's faith/spiritual beliefs.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					



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	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
14. Staff spoke with me in a way that I understood.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					

15. Staff was sensitive to my cultural/ethnic background.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					

16. My child got services in a reasonable amount of time.					
Family Support Organization (FSO)					
Care Management Organization (CMO)					
Youth Case Management (YCM)					
Contracted Systems Administrator (CSA)					
Mobile Response Stabilization System (MRSS)					
Behavioral Assistance (BA)					
Intensive In-Community Services (IIC)					
Out-of-Home Placement Services (OH)					

As a result of the services my child and/or family received:	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
17. My child is better at handling daily life.					
18. My child gets along better with family members.					
19. My child gets along better with friends and other people.					
20. My child is doing better in school and/or work.					
21. My child is better able to cope when things go wrong.					
22. I am satisfied with how our family gets along with each other.					
23. My child has stayed free of new police or court involvement.					
24. I would refer a friend for services within DCBHS.					



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25. What has been the most helpful thing about the services you and your child received over the last year?

26. What would improve the services?

27. Zip Code: _____ (optional)

28. Your Child's Race (check one):

- ☐ Asian
☐ African American/Black
☐ American Indian/Alaskan Native
☐ Bi or Multi-Racial
☐ White
☐ Native Hawaiian/Other Pacific Islander

Are You Hispanic/Latino?

- ☐ Yes
☐ No

29. Your Child's Gender (check one): ☐ Male ☐ Female

30. Your Child's Age (check one):

- ☐ 0 - 4
☐ 5 - 10
☐ 11 - 13
☐ 14 - 17
☐ 18 - 21
☐ Over 21

31. How long has your child been receiving CBHS Services? (check one):

- ☐ Less than 1 month
☐ 1 - 2 months
☐ 3 - 5 months
☐ 6 months to 1 year
☐ 1 year to 2 years
☐ Over 2 years

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